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ANNUAL REPORT
OF THE
SUPERINTENDENT OF INSURANCE
TO THE
NEW YORK LEGISLATURE

CALENDAR YEAR 1992

MARIO M. CUOMO
GOVERNOR

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SALVATORE R. CURIALE
SUPERINTENDENT OF INSURANCE

May 15, 1993

To the Legislature:

The Annual Report of the Superintendent of Insurance for the year ending December 31, 1992 is herewith submitted in accordance with Section 206 of the Insurance Law.

Respectfully submitted,

Salvatore R. Curiale
Superintendent of Insurance

ONE HUNDRED THIRTY-FOURTH

ANNUAL REPORT

OF THE

SUPERINTENDENT OF INSURANCE

A Report to the Legislature
for the Year Ending
December 31, 1992

SALVATORE R. CURIALE
SUPERINTENDENT OF INSURANCE

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THE STATE OF STATE REGULATION
by Superintendent Salvatore R. Curiale

The following is based on testimony delivered by Superintendent Curiale on September 9 before the U.S House of Representatives Subcommittee on Oversight & Investigations of the Committee on Energy and Commerce. The Subcommittee is chaired by Representative John Dingell (D-Michigan).

The New York State Insurance Department, with our 132-year history of effective regulation of the insurance industry, has long been recognized as a leader in the preservation of insurer solvency and the protection of insurance consumers. From the Armstrong Committee hearings on the life insurance industry in 1905 to the establishment in the mid-1980s of "flex-rating" rules for commercial liability insurance policies, from the Department's pioneering junk bond regulation in 1987 to our present-day efforts at the NAIC to create risk-based capital guidelines for insurers, the New York Department has been at the forefront of innovative solvency regulation. It is a tradition we are committed to maintain.

This is not to say that we are blind to the problems that have arisen over the past decade in New York and in other states. However, I believe such problems are not endemic to our system of regulation; they would exist in any insurance regulatory system operating within a competitive, marketplace economy. No regulatory system in the United States is designed to prevent failure in each and every case, nor should it be. The true test of the worth of any system is how well it responds to stress. I firmly believe that the state regulatory system of insurer oversight has demonstrated its ability to respond effectively and efficiently to the problems and unprecedented economic conditions of the past decade.

The Department's Record

The high interest rate environment of the late 1970s/early 1980s led to extreme rate cutting and cutthroat competition among property/casualty insurers writing commercial liability lines in the mid-1980s. Once investment returns began to decline, however, the inadequate rates and "cash-flow" underwriting that insurers had engaged in during the soft market began to produce dramatic losses for property/casualty insurers. This adverse experience led many insurers either to withdraw from certain market segments or to greatly increase their prices.

New York responded to these availability, affordability and solvency problems in a number of ways:

(1) market assistance programs to bring buyers and sellers together;
(2) "flex-rating," intended to keep insurance costs relatively steady and predictable for consumers as well as to permit established insurers to compete with newly developing alternative markets;
(3) enhanced capital requirements, especially for reinsurers which play a necessary role in the spreading of risk and, therefore, the availability of products;

(4) regulation of reinsurance intermediaries which play an important role in the risk-spreading process;
(5) monitoring the use of managing general agents, which insurers had utilized because they were eager to garner business in new or unfamiliar insurance markets without sufficient control of where the business came from, what its characteristics were and what its ultimate costs were likely to be;
(6) enhanced financial reporting requirements involving CPA reports, actuarial certifications, prescribed treatment of certain defined transactions, and computerized annual statements, which provided better data to allow for more accurate financial analyses of insurers' operations and condition; and
(7) regulation of financial reinsurance, which prohibited the distortion of operating results that occurs when reinsurance arrangements do not transfer underwriting risks.

Rising interest rates in the late 1970s also created new and complex problems for life insurers. The influx of new interest-sensitive products dramatically changed the nature of the life insurance industry during the 1980s. In order to maintain their competitive position with other financial services sectors, life insurers developed new products which consumers found attractive, but which required supporting assets with rates of return that were significantly higher than the rates for assets supporting more traditional life insurance products. Of course such high rates of return were accompanied by higher risks.

New York's response included:

(1) a regulation limiting exposure to junk bonds at a time when virtually no other regulatory body was acting to restrict such investments;
(2) a regulation requiring the "matching" of an insurer's assets and liabilities;
(3) regulations to ensure strong controls over reinsurance transactions; and
(4) enhanced financial analysis techniques based on the risk profiles of life insurers (risk-based capital).

Nationwide, the improvements in the quality of insurance regulation have originated mainly from the already existing state regulatory system and, in some measure, can be ascribed to the efforts of the New York Department. We have been a prominent participant in almost every major effort by the NAIC to create model laws and regulations and effect regulatory improvements, such as:

(1) New York was instrumental in amending the Annual Statement blanks and developing a companion automated reporting system, in order to improve the quality and relevance of data reported in financial statements;
(2) New York led the efforts to enact effective model legislation regarding proper control of holding company transactions, reinsurance credit allowance, proper reporting of loss portfolio transactions, control of fronting arrangements, and control over the use of managing general agents and reinsurance intermediaries; and

(3) New York chairs the two national working groups formulating risk-based capital requirements for life and property/casualty insurers.

Effectiveness of State Regulation

Over the past several years, various groups have graded the effectiveness of insurance regulation by the states. While these critiques revolve around a multitude of insurance regulatory matters, they all fail to grasp the enormous complexities involved in monitoring the insurance industry's financial condition.

No regulatory system can or should guarantee that insolvencies will not occur. In a competitive, free enterprise environment, some insolvencies are inevitable, and perhaps salutary. The alternative, found in some countries, is to permit a relatively small number of insurers to offer a limited number of products at rates high enough to assure solvency but at a level that is overly burdensome to its citizens. One goal of insurance regulation is to prevent the insolvencies that do occur from disrupting the marketplace and placing undue hardships on consumers.

In New York I believe we have achieved such a goal. Historically, the net cost to New York policyholders due to insurer insolvencies has been negligible. Over the past five years, assessments by New York's Property/Casualty Insurance Security Fund have, on average, added less than one-half of 1% to policyholders' annual premiums. During the 15 years prior to 1988, the Property/Casualty Fund made no assessments at all. Similarly, New York's life insurance guaranty funds have, over their 50-year history, had no net cost to policyholders (during this period, there was only one significant assessment, of $6 million, all of which was eventually returned with interest to the assessed life insurers, with no tax offset).

Acting in haste is not always the wisest policy. If the Department had taken abrupt steps to liquidate various medical malpractice insurers in the mid-1980s, based upon what then appeared to be massive insolvencies, the cost to policyholders and our guaranty fund would have been astronomical and the disruption to the marketplace severe. At that time, some of the leading actuaries in the country had concluded that medical malpractice rates were at least 50% inadequate and that virtually every writer of this coverage in New York was deeply insolvent. But liquidation of these insurers would have placed a crushing burden on our Property/Casualty Insurance Guaranty Fund. The ultimate net cost to other liability insurance policyholders, in the form of additional premium charges, could have reached $2 billion. Instead, working with the insurers and the Legislature, we were able to avert a potential crisis by cooperating in the enactment of a program of reform legislation that by 1990 helped to rescue New York's medical malpractice system from catastrophe. In recent years malpractice rates have actually been reduced,and collectively our medical malpractice insurers now boast a positive surplus.

Solvency Recommendations

In my testimony before Representative John Dingell's Subcommittee, I offered six proposals for Congressional action which could, I believe, enhance the effectiveness of state regulation of insurance. Each could be accomplished with a minimum of federal involvement and expense. They are:

1. **Limit Interstate Sales to Insurers Domiciled in Accredited States:** This proposal would provide state insurance departments with the necessary resources some now lack by putting sharper teeth into the NAIC accreditation program. The program needs meaningful sanctions against insurers domiciled in non-accredited states. Congress can provide the most effective sanction by limiting the interstate sale of insurance to insurers domiciled in accredited states. Under such a law, insurers domiciled in unaccredited states would be barred from writing insurance beyond their borders and an insurer domiciled in an accredited state would still need to obtain a license in each state in which it wishes to conduct business. This latter requirement would ensure that minimum NAIC standards do not become maximum standards for all states.

Many state insurance departments are now trying to enact the necessary laws and obtain the requisite resources for their states to qualify for NAIC accreditation. But these are difficult economic times. Although state legislatures may be receptive to enacting legislation, a number are not yet committed to providing the funding needed by their insurance departments to pay for vital personnel and other resource enhancements. A federal law prohibiting interstate transactions for an unaccredited state's domestic insurers after a given date should send a wake-up call to many state legislatures.

Ultimately, with this added sanction and the continuation of individual state licensing, the accreditation program would accomplish many of the goals of proponents of federal regulation. It would enable states to rely more heavily on their licensees' states of domicile, resulting in more efficient regulation. It would further harmonize multi-state regulatory requirements, to produce regulation that would be reinforcing rather than redundant. And it would strengthen the ability of the most responsible accredited states to bring other states up to their level, which would, in turn, ensure that regulation emphasizes long-term solvency and at the same time responds to changing industry conditions.

2. **Reform the State Guaranty Fund System:** A uniform guaranty fund law (with separate funds for life, health and property/casualty insurance) should be enacted, including a federal requirement that each state adopt the law without modification. Coverage with respect to claims against large commercial policyholders could be revised so that guaranty funds would continue to protect claimants but would retain a right to reimbursement from these more sophisticated policyholders. I believe this approach would be superior to the development of a single national fund, because a single fund would allow a politically motivated state to sacrifice financial solidity in favor of low prices, knowing that policyholders of a failed insurer in that state would be covered by contributions from the other 49.

3. **Enact a Uniform Rehabilitation and Liquidation Law:** Third, I recommend the enactment of a Uniform Rehabilitation and Liquidation Law. The current system, with one primary receiver and up to 49 ancillary receivers, is expensive and unduly time consuming. A process similar to the one proposed in H.R. 4900, coupled with a uniform guaranty fund law, would result in a more efficient and equitable liquidation process.

4. **Reform ERISA:** The Employee Retirement Income Security Act (ERISA) exempted welfare funds from state regulation, effective January 1, 1975. From 1956 until the 1975 pre-emption, the New York Insurance Department had actively regulated some 1,600 such funds, via registration, annual reporting requirements, periodic on-site examinations, rules on permissible investments, prior approval of major transactions, the removal and prosecution of untrustworthy trustees, and the recovery of misappropriated or embezzled funds. The Department also handled complaints and inquiries from thousands of members. Under ERISA, the Labor Department became the designated regulator, but it has neither the resources nor the power to regulate effectively.

In 1983 ERISA was amended, in response to growing complaints about unpaid medical bills tendered to welfare benefit plans that had been created by unions and other employee organizations covered by the ERISA exemption. The 1983 amendment permitted "multiple employer welfare arrangements," or MEWAs, that were subject to dual regulation. The statute, however, was vague with respect to the regulatory and jurisdictional roles of the states and the federal government. As a result, unscrupulous operators can now tie up the states and the U.S. Labor Department in endless litigation while the operators continue to perpetrate insurance frauds throughout the country.

Congress needs to reform ERISA and either return the regulation of welfare funds providing medical benefits to the states or adequately fund the Labor Department and direct it to actively oversee MEWA operations.

5. **Improve the Federal Liability Risk Retention Act:** A second exemption from state regulation is in the Liability Risk Retention Act of 1986 (LRRA), under which federal purchasing groups may be created to engage in group purchases of liability insurance. Although the announced purpose of the LRRA was to increase the availability of affordable liability insurance coverage, in practice the Act has resulted in hardships for consumers and undue burdens on state insurance regulators.

The Act intended that purchasing groups would be formed and controlled by the groups' members in order to improve their bargaining position with insurers. In reality, some federally authorized purchasing groups have often worked to the detriment of policyholders and to the benefit of insurers. The LRRA does not prohibit insurers or intermediaries from organizing purchasing groups that are then used to circumvent state requirements for policy forms and rates. The LRRA became law at the height of the commercial liability crisis of the mid-1980s. The need for such organizations at this time--a period in which commercial liability insurance is readily available--is not apparent.

Unsophisticated policyholders and claimants have suffered under the LRRA. In one particularly abusive case that occurred in New York, a licensed insurer, which was the sole provider of liability coverage for nurse practitioners, sent nonrenewal notices to its insureds and simultaneously offered, through membership in a purchasing group organized by an unlicensed affiliate, to replace the same coverage at a rate 15 times the previous rate. At least three purchasing group insurers have so far become insolvent, leaving policyholders and claimants unprotected by any state insolvency fund.

Federal risk retention groups (RRGs), authorized by the same LRRA to underwrite commercial liability insurance on similarly related risks located in all states after obtaining a license from any one state, generally organize in states with the least oversight and the lowest level of capital and reporting requirements. Often doing little or no business in their "domiciliary" states, RRGs create serious market problems in states where they actually do conduct business. Four RRGs have already become insolvent, with no state or federal security fund to protect innocent third-party claimants.

The LRRA should be amended to subject RRGs to meaningful solvency regulation comparable to that of other insurers of commercial liability risks. Given the federal government's concern for the financial viability of U.S. insurers, I am puzzled by its lack of attention to these largely unregulated entities.

For purchasing groups (PGs), a bill currently before the House (H.R 385) would correct the loophole that permits their organization and control by insurers, but would open an even larger loophole by permitting PGs to pick their own regulators. A state selected by a PG as its principle place of business would, under the bill, become the insurer's sole regulator with respect to the coverage provided. The designated state would not have to be a state in which the insurer did any business or even one in which it was licensed. Purchasing group members are generally not sophisticated buyers of insurance, and I would strongly recommend eliminating this further dilution of state regulatory oversight. Since one state could not constitutionally or practically regulate market practices in the other states, PGs would enter a regulatory void in which neither policyholders nor claimants would be protected.

6. Enact Insurance Fraud Legislation: Finally, I urge the enactment of the insurance fraud legislation currently before Congress. In the spring of 1991 members of the National Association of Insurance Commissioners drafted legislation making insurance fraud a federal crime. Since that time, both houses of Congress have legislation substantially similar to the NAIC version, but at this writing the legislation is stalled in the Senate.

Designating insurance fraud as a federal crime would significantly elevate the penalties associated with such insurance crimes as embezzling money and premiums, theft, filing false reports or making false statements with respect to the financial condition of an insurer, making false entries, and obstructing regulatory or judicial proceedings. The passage of meaningful federal anti-fraud laws statutes will go a long way toward helping individual states cope with the problems associated with insurance fraud.

Conclusions

State regulators should be held accountable for the overall health of the insurance industry in their respective states. As state regulators, the New York Insurance Department accepts such accountability. I believe that a fair accounting would show, to paraphrase Mark Twain, that reports of the insurance industry's imminent demise are grossly exaggerated. Despite some of the problems of the last decade, the industry remains in overall good health. The stresses it is experiencing are being addressed by both the industry and its regulators in a responsible, efficient and proactive manner.

Certainly there is room for improvement in any system, particularly any regulatory system. The states and the NAIC have recognized their imperfections and have made great strides in recent years toward enhancing regulation for solvency and fair policyholder treatment. But we are not complacent. We expect over the next few years to see further progress in the quality of state regulation and a continuing demonstration of the states' will to regulate.

To those advocating major structural change in the regulation of an industry that has been successfully regulated by the states for well over a century, I say: Please consider the alternatives! Ask yourselves whether a substitute system would produce problems of a significantly greater magnitude than those we are now addressing. Abandoning our present regulatory structure might very well mean abandoning the principle of accountability so crucial to effective regulation. And in an atmosphere in which no one is held accountable for the financial health of the insurance industry, it's the American insurance consumer who suffers the greatest.

MAJOR DEVELOPMENTS
1992

Community Rating And Open Enrollment

In 1992, the community rating and open enrollment health insurance reform package dominated the insurance legislative landscape. The controversial bill, long a top priority with the Department, was passed by the Legislature during the final days of its 1992 session and signed by Governor Cuomo on July 17, 1992. The bill became Chapter 501 of the Laws of 1992.

The bill was first introduced as a Governor's Program Bill in 1991, but died quietly in committee that year. In March 1992, Assemblyman Pete Grannis (D-65th Dist.), newly named Chairman of the Assembly Insurance Committee, took the core of Governor Cuomo's legislation and incorporated other provisions, including one that mandated a management audit of Empire Blue Cross/Blue Shield.

Chapter 501, which became effective on April 1, 1993, requires all health insurers of small group and individuals to sell to any applicant, regardless of age, sex, occupation or prior health history. Rates for such coverages are based on an insurer's entire pool of small group or individual business in a particular territory. Another key feature of the new law is "portability," which means no New Yorker who changes jobs need now fear serving a new pre-existing condition waiting period if he or she previously served one under a substantially similar policy.

Prior to the implementation of community rating and open enrollment, commercial health insurers were permitted to pick and choose the healthiest applicants, leaving the poorest risks to the insurers of last resort in each territory, i.e., the Blues. The State's largest health insurer--Empire Blue Cross and Blue Shield--was hit particularly hard by such "cherry-picking." The more good risks that left the company, the higher the premium rate increases for those that remained, which prompted more good risks to depart, putting more upward pressure on rates. Empire's policyholders, many of whom had nowhere else to turn, became hapless victims caught in a health insurance maelstrom.

Since Chapter 501 did not become fully effective until April 1993, Empire's financial woes continued. The company sued the Department on July 30 after Superintendent Curiale made it clear that no further rate increases would be granted the company during 1992. Earlier in the year, Superintendent Curiale had granted Empire half of a proposed 28% rate increase for its small group and individual policyholders.

In the fall, Empire returned. This time with a 25.5% weighted average increase on its community-rated small group and individual contracts. This time, however, the rapidly deteriorating financial condition of Empire Blue Cross and Blue Shield prompted the Superintendent to grant the full increase, effective January 1, 1993.

Early in 1993, Governor Cuomo and the New York State Legislature agreed to settle an outstanding lawsuit between Empire (and several other insurers) and New York State, provided the funds would be used to lower the premium increases for those hardest hit by the Superintendent's decision. The lawsuit was seeking to recover shares of $210 million that had been transferred from New York State's excess medical malpractice insurers to the State's General Fund over the previous two years. Empire was expected to realize about $100 million by year-end 1993 as a result of the agreement.

The agreement ensured that no premium rate increase for any community-rated contract would exceed 25%. As a result of the agreement, the average increase for all subscribers was reduced from 25.5% to 19.5%.

By requiring community rating and the provision of coverage on an open-enrollment basis for individual health insurance and health insurance offered to groups of 50 or fewer persons, Chapter 501 is expected to facilitate access to health insurance by New York residents. The legislation also promotes competition among insurers on the bases of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs rather than on the basis of differing underwriting and rating practices. Because the new law tends to adversely affect those groups that were previously written by the commercial carriers--namely the young and the healthy--it generated numerous complaints during the months leading up to its implementation. As of this writing, however, indications are that markets are opening up and the law is working.

Chapter 501 was never intended as a panacea. It must be viewed as a first step in a process designed to address problems with the structure of the current health insurance finance system. For example, the goal of Chapter 501 to promote competition among insurers on bases other than risk selection may not be accomplished if insurers are permitted to develop and offer a multiplicity of benefit packages, each with its own pool of policyholders, and each with its own community rate. By legislatively mandating standardized benefit plans, individuals and small groups would be able to easily compare offerings from competing insurers. Insurers would not be able to attract better risks from comprehensive benefits plans by offering limited benefits policies at reduced rates.

On the federal level, the Employee Retirement Income Security Act of 1974 (ERISA) generally pre-empts state regulation of self-insured plans. This pre-emption of state regulatory authority has permitted such plans to avoid the mandates of state insurance regulation, including Chapter 501. If New York is to develop a comprehensive health care financing mechanism applicable to all players in the system, legislation will be required at the federal level to curtail ERISA's broad pre-emption of state laws pertaining to the regulation of health care and health care financing.

Property/Casualty Insurance

They go by innocuous-sounding names like Andrew and Iniki and even "The Storm With No Name" but they packed a wallop that caught the attention of U.S. property/casualty insurers in 1992. These "acts of God" along with the Los Angeles riots and a variety of other calamities that can seem minor only in comparison made 1992 the worst year on record for property damaged by natural and man-made disasters.

Insured losses in 1992, which some estimates put at more than $21 billion, dwarfed those of 1989, the previous recordholder, when Hurricane Hugo and the San Francisco earthquake combined with several other disasters for a $7.6 billion payout by property/casualty insurers.

Hurricane Andrew alone accounted for the most extensive losses. The storm made landfall on August 24 and moved across south Florida and the Louisiana gulf coast, leaving upwards of $16 billion of insured property damage in its path. It was the fiercest storm to hit the U.S. in 35 years, with losses causing the collapse of six relatively small Florida insurance companies and threatening the solvency of its guaranty fund.

While the industry was still reeling from the devastating effects of Andrew, Hurricane Iniki hit Hawaii on September 11, causing an estimated $1.6 billion in insured property damage. Iniki was the worst storm to hit Hawaii this century and only the fact that its force was fixed on one of the less populated islands in the chain prevented much more severe damage.

The Los Angeles riots in April will be recorded as one of the costliest civil disturbances in U.S. history, with losses to property/casualty insurers put at $775 million. April also saw severe storms hit Texas and Oklahoma that resulted in $760 million in covered losses. And before the end of June, a flood under the streets of Chicago would add another $300 million to the industry's costs.

These events, in addition to any number of hailstorms, floods and as many as 88 tornadoes during one November weekend, served to break all records for total costs in catastrophic claims even before the third quarter came to a close. And then, just weeks before the end of an already horrendous year, a Nor'easter, dubbed The Storm With No Name, hit the east coast with floodwaters and winds of up to 60 miles an hour causing $650 million in covered losses before it subsided three days later. The greatest insured property damage occurred in New York State with $220 million in losses to homes, businesses, automobiles and boats, particularly in coastal areas.

Much of the damage from the Nor'easter, as well as Hurricanes Andrew and Iniki and other such storms, was the result of flooding and as such is routinely excluded from homeowners and commercial property insurance policies. However, many of the properties were covered by the National Flood Insurance Program, a government-sponsored program that provides affordable protection against flood losses.

Members of the Department's Consumer Services Bureau helped staff the Governor's toll-free hotline on a 24-hour basis. In addition, Bureau insurance examiners worked at nine disaster assistance centers set up around the State by the Federal Emergency Management Agency (FEMA), answering questions and assisting consumers with insurance claims.

The Bureau also contacted the major property/casualty insurers to obtain estimates of losses that were used by the State Emergency Management Office (SEMO) and federal agencies to help support the request for designating New York State a federal disaster area.

Underwriting ratios reached record levels in 1992 as well, with property/casualty insurers paying out $1.16 in claims for every $1 in premiums written, yet premiums remained relatively stable through the early months of 1993 except in Florida and Hawaii. One reason the soft market has continued in 1993 despite devastating losses is that property/casualty insurers took advantage of low interest rates last year and sold off a hefty portion of their bond portfolios resulting in more than $10 billion in realized capital gains for 1992. In fact, the industry's surplus actually increased from

$158.7 billion in 1991 to $163.8 billion last year.

New York was, however, not left untouched by the effects of the 1992 disasters. Several insurers--most notably Allstate, Travelers and GEICO--informed the Department in early 1993 that they intended to restrict new writings in various coastal areas in the Long Island region. At this writing, it appears that a sufficient number of other property/casualty insurers are still participating in the market and sufficiently able to fill the void.

Life Insurance

Executive Life Insurance Company of New York

In January 1992 Superintendent Curiale announced an agreement with the Metropolitan Life Insurance Company (MetLife) that would compensate, without guaranty fund assistance, all Executive Life of New York (ELNY) contractholders. Under the plan MetLife agreed to acquire ELNY's single premium deferred annuity business, worth about $1.2 billion, as well as ELNY's life insurance business valued at approximately $260 million. Under the agreement, annuitants and life insurance contractholders who moved to MetLife would receive 100% of their money plus interest. The agreement also called for ELNY's continuing payment liabilities (pensions and structured settlements) to remain under the supervision of the Department's Liquidation Bureau, with MetLife administering payments.

Executive Life of New York was placed in rehabilitation by the New York Insurance Department some nine months prior to the announcement of the agreement. Although Superintendent Curiale stressed at the time of the rehabilitation that ELNY--a $3 billion company--was neither insolvent nor impaired, the company had experienced a flood of surrender requests following the seizure by California regulators of ELNY's west coast parent, the Executive Life Insurance Company of California.

Opposition to the ELNY Plan of Rehabilitation by some agent groups helped delay final court action until December 16, 1992 when Judge Leo F. McGinity of Nassau County State Supreme Court approved the agreement, thus clearing the way for a March 15, 1993 implementation date.

Superintendent Curiale credited the Liquidation Bureau for its prudence and creativity in shepherding the plan to completion, as well as the Life Companies Bureau that had worked prior to the rehabilitation effort to ensure that the company ultimately would be able to meet its obligations.

Mutual Benefit Life Insurance Company

About the same time the Court was approving the Executive Life agreement, the Superintendent was giving his go-ahead to another plan that promised significant benefits to New York policyholders. This time the company was Mutual Benefit Life Insurance Company, a New Jersey company that was licensed in New York as well as all other states. Mutual Benefit was placed in rehabilitation by New Jersey regulators in July 1991 and announced a rehabilitation plan a year later.

Superintendent Curiale was immediately critical of the plan, indicating its inconsistency with New York statutory requirements. The plan, as devised by the New Jersey rehabilitators, called for a 3.5% credited interest rate and a seven-to-twelve year moratorium period for all policyholders and annuitants. Forty-seven other state guaranty funds signed on with the New Jersey plan during the last half of 1992. Under New York Law, the Superintendent must agree to any Life Insurance Company Guaranty Corporation (LICGC) decision to participate in an out-of-state rehabilitation plan.

As negotiations continued between the Superintendent and the LICGC, New Jersey announced it was boosting its credited rate from 3.5% to an annual average of 5.0%. As a result of the New York agreement, however, New York policyholders will get more than their counterparts throughout the country. Specifically, any New York resident with a Mutual Benefit contract covered by the guaranty fund will receive a ''market'' interest rate pegged to rates on 3-year Treasury Bills. From July 16, 1991, the date Mutual Benefit was placed in rehabilitation, until December 31, 1993, that rate will be 5.75%.

Moreover, certain New Yorkers meeting eligibility requirements will be provided full surrender rights on their Mutual Benefit policies or annuities as of July 16, 1996. The Superintendent's view is that such surrender rights are guaranteed by the New York's life insurance guaranty fund.

In addition, as a result of the agreement the life insurance guaranty fund will extend guaranty fund protection to various group annuity contract participants who would not otherwise be eligible for such benefits.

The Mutual Benefit agreement represented a significant victory for New York policyholders who were left in the lurch as a result of the New Jersey rehabilitation. Moreover, without New York intervention, it is unlikely policyholders in other states would have benefited from the 1.5 percentage point enhancement to their credited rates of interest.

In a related matter, the New York State Insurance Department revealed last summer that Mutual Benefit had paid over $30 million in illegal subsidies to a number of its insurance agents. The findings came as a result of a limited audit of the New Jersey-based company to determine if it had adhered to New York's strict expense limitation rules.

The Department announced that under normal conditions, Mutual Benefit would have been fined in excess of $300,000 for its infractions, thus making the fine the largest ever assessed against a life insurance company. The Department decided, however, not to assess any financial penalty against the company in order that Mutual Benefit's remaining assets be used to fully benefit the company's policyholders.

The Equitable Life Assurance Society of the United States

A plan to demutualize The Equitable Life Assurance Society of the United States was approved by the Superintendent on May 12, 1992. Equitable's plan to convert from a domestic mutual life insurer to a domestic stock life insurer as a means to raise capital was adopted by its Board of Directors in November and submitted to the Department in December 1991.

THE
EQUITABLE

A public hearing was held in April on the fairness of the terms and conditions of the plan, the reasons and purposes for Equitable to demutualize, and whether the reorganization was in the interest of Equitable and its policyholders, and not detrimental to the public. Over 92% of the 888,338 Equitable policyholders who cast ballots voted in favor of the plan.

Axa, a large French insurer, invested a total of $1 billion in Equitable in July 1991 and is obligated to convert its investment into equity upon completion of the demutualization.

Living Benefits

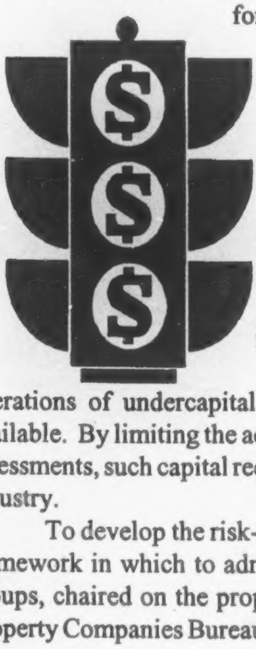
New protections are now in place that will allow seriously ill New York State residents to receive death benefits from their own life insurance policies while still alive. A life insurer may choose to offer policies that allow terminally ill policyholders with a year or less to live to receive accelerated death benefits (living benefits). An insurer may also offer these benefits regardless of life expectancy if the policyholder has a specified medical condition, such and AIDS, that requires extraordinary medical care.

Living benefits can help individuals meet the devastating medical bills that often accompany serious illness. While life insurance policies provide cash surrender and loan values that may be used to meet the financial needs of these individuals, the amounts available are usually substantially less than the face amount of coverage. The living benefits rules, incorporated into Regulation 143, were effective May 13, 1992.

Since the effective date of the Regulation, 15 insurers have received approval of accelerated death benefit riders or policies and 9 insurers have received approval of group accelerated death benefit products.

Risk-Based Capital

The capital adequacy of insurers is of paramount concern to regulators who work to assure a healthy and viable insurance market. Most states set a fixed-dollar minimum capital requirement for insurers doing business within their borders. This fixed minimum may be appropriate for start-up operations, but it is neither relevant nor appropriate for measuring the capital adequacy of an established insurer.



In 1990, the National Association of Insurance Commissioners (NAIC), as part of its solvency agenda, began to develop risk-based capital requirements for insurers. This project underscores the NAIC's belief that fixed-dollar minimum capital requirements for insurers are unrealistic and archaic; capital should be related to the risks inherent in an insurer's operations; and financial institutions should be well capitalized in order to deliver on their promises.

Meaningful capital standards will enable regulators to intervene in the operations of undercapitalized insurers and require corrective action when resources are still available. By limiting the activities of unhealthy competitors and reducing the cost of guaranty fund assessments, such capital requirements benefit policyholders while they serve the best interests of the industry.

To develop the risk-based capital formula and a model act that would establish the statutory framework in which to administer the formula, the NAIC established risk-based capital working groups, chaired on the property/casualty side by Vincent Laurenzano, Chief of the Department's Property Companies Bureau, and on the life side by Terence Lennon, Chief of the Life Insurance and

Companies Bureau.

A risk-based capital formula and model act for life and accident & health insurance companies was adopted by the NAIC in December for inclusion in the 1993 annual statements to be filed by March 15, 1994. The formula not only will help bolster capital and enhance confidence in the industry, but can be used by regulators as an early warning indicator of financial instability. A similar formula and model act has been proposed for property/casualty insurance and the NAIC working group is hoping for adoption in December.

Supplementary Uninsured Motorists Endorsement

In July, the Department promulgated Regulation 35-D which requires insurers to offer a prescribed Supplementary Uninsured Motorists (SUM) endorsement to enable policyholders to recover damages resulting from accidents involving other motor vehicles that are uninsured or, even if insured, are insured for third-party bodily injury (BI) at relatively low liability limits. For example, a driver with $100,000 of BI liability coverage would be protected against lawsuits up to that $100,000 limit. However, that same driver's ability to recover damages would be severely limited if he were to sustain serious injuries as a result of an accident with someone who had only $10,000 of BI coverage. If the first driver had purchased SUM coverage up to his BI limits, he could recover up to $100,000 in damages in total.

The Regulation is considered necessary to address the problems created by the marketing of varying supplementary uninsured motorists endorsements by insurers. Insurers, in developing their own individual SUM endorsements, have attempted to interpret Section 3420(f)(2) of the Insurance Law, the legislation that requires them to offer SUM coverage, and have also attempted to reflect various court decisions that have interpreted both the law and the individual endorsements. The prescribed endorsement should reduce much of the confusion regarding SUM coverage, make it easier to collect benefits recoverable under the coverage and, when disputes arise, make it simpler to resolve those disputes.

The Department's authority to promulgate the Regulation was challenged by the National Association of Independent Insurers, Government Employees Insurance Company, United Services Automobile Association and State Farm Insurance Company. The petitioners challenged certain provisions contained in the Regulation and were granted a stay that prohibits the Department from enforcing the Regulation.

The Department's authority to promulgate the Regulation was upheld by New York State Supreme Court and, upon appeal, unanimously by the Appellate Division, First Department. The petitioners had indicated that they will request leave to appeal to the New York State Court of Appeals. The Regulation was originally designed to take effect October 1, 1992, but that date will be amended, provided the Department prevails.

New Medicare Supplement Standards

New rules standardizing and simplifying Medicare supplement insurance policies were established by the Department in March to further assist consumers in comparing and buying such coverage. The rules, contained in the Seventeenth Amendment to Regulation 62, permit the sale of ten standard Medicare supplement policies in New York State. The policies offer a variety of choices, ranging from basic benefits to a comprehensive package.

Medicare supplement insurance, also called medigap insurance, is designed to provide additional hospital, medical or surgical coverage beyond what is covered by Medicare. Medicare is the federal health insurance program primarily for persons aged 65 and older.

These new rules are based on a National Association of Insurance Commissioners (NAIC) Model Act and Regulation which was adopted July 30, 1991. The federal government in 1990 enacted legislation that required the simplification of Medicare supplement policies, tightening of federal penalties regarding the sale of duplicate coverage, and the establishment of policy renewability standards. The Department has incorporated the new standards into the Seventeenth Amendment to Regulation 62.

Auto Insurance Refunds

As a result of a joint investigation conducted by the Insurance Department and the New York State Attorney General's office, 70 automobile insurance companies agreed to pay refunds to consumers who had been overcharged. The settlement was expected to provide over $38 million in reimbursements to New York motorists. The refunds, which will be made available to motorists throughout the nation, are the result of a major investigation into the failure of the country's largest auto insurers to give legally required discounts to consumers with safety and anti-theft devices in their vehicles. Many of the companies actually advertised the discounts and still failed to provide them.

Discounts of between 5% and 30% are required when an automobile has certain safety devices, such as airbags, automatic seat belts and anti-lock brakes. Similar discounts are required for car alarms and other anti-theft devices. The settlement provides an average refund of $50 for cars that have anti-theft devices, and an average of $25 for vehicles with passive restraints. The refund must be made for each year that the motorist qualified for a discount.

Continuing Education Law

In July 1992, Governor Cuomo signed into law continuing education legislation applicable to all New York insurance agents, brokers and consultants. New York joins more than 30 other states in requiring licensees to keep pace with industry developments and changes in applicable laws by participating in continuing education programs. Continuing education is also widely recognized as a means of enhancing the professionalism and expertise of, and instilling consumer confidence in, insurance professionals.

The New York continuing education requirements, an addition to Article 21 of the New York Insurance Law, mandate that agents, brokers and consultants accumulate a minimum of 15 approved continuing education credits during each biennial license period.

The accumulation period for continuing education credits will begin upon renewal of licenses in 1994 and 1995, with documentation of accumulation of required credits part of the renewal of those licenses in 1996 and 1997.

Health Insurer Complaint Ranking

The Department issued the 1991 Annual Health Insurer Complaint Ranking on December 15, 1992. The report was the first ranking of consumer complaints against health insurance companies, health maintenance organizations and nonprofit health service corporations.

The report ranked 89 companies represented by 46 groups by the number of upheld accident and health complaints as a percentage of premium volume in New York State. The Department expects to publish such guides each year at this time in accordance with Section 210 of the Insurance Law enacted in May 1991.

Current Issues Seminars

The Policy and Planning Bureau coordinates the Department's in-house seminars on current issues. The first seminar, held in February 1992, addressed some of the policy issues surrounding health insurance. In June, the subject was ''Policy Issues in Tort Liability,'' providing an objective overview of occurrences in the world of tort litigation. The third seminar, ''Perspectives on Long-Term Care Insurance,'' was held in December. The panel included speakers representing the regulation of nursing homes and home health care, the insurance industry, and the Insurance Department.

Attendance at Department seminars are restricted to about 100 Department professionals, but are video taped for those unable to attend. Seminars planned for 1993 will center on such issues as risk-based capital, the NAIC accreditation program and national health insurance.

I. GENERAL REVIEW OF NEW YORK STATE INSURANCE BUSINESS

A. LIFE INSURANCE AND COMPANIES BUREAU

1. Licensed Life Companies

There were 144 life insurance companies were licensed to transact business in New York at December 31, 1992.

Total admitted assets of licensed life insurers amounted to $920.9 billion at December 31, 1991, a ten-year gain of 147.1%. Bonds totaled $398.2 billion; stocks $31.0 billion; mortgage loans $188.2 billion; real estate $27.7 billion; policy loans $41.5 billion, and short term investments $19.9 billion Other admitted assets totaled $214.4 billion.

2. Domestic Life Companies

Domestic life insurance companies had admitted assets of $329.5 billion at December 31, 1991, an increase of 131.2% since 1981. Insurance in-force at December 31, 1991 of $2.2 trillion represents an increase of 124.0% since December 31, 1981.

3. Savings Bank Life Insurance

There were 35 banks issuing savings bank life insurance at the close of 1992. Total ordinary and group life insurance in-force at December 31, 1992 amounted to $21.3 billion. Admitted assets totaled $997.3 million.

4. Organizations Under Life Insurance and Companies Bureau Supervision

The Life Insurance and Companies Bureau supervised 413 organizations as of December 31, 1992. These organizations consisted of: 144 licensed life insurance companies--88 domiciled in New York and 56 foreign; 50 fraternal benefit societies--8 domiciled in New York, 41 foreign and 1 United States Branch of a Canadian Society; 35 life insurance departments of New York mutual savings banks; 13 retirement systems--5 private pension funds and 8 governmental systems; 8 governmental variable supplements funds; 63 segregated gift annuity funds; 24 employee welfare funds and 76 accredited reinsurers.

Table 1
ADMITTED ASSETS
Life Insurance Companies Licensed in New York State
Selected Years, 1981-1991

(dollar amounts in billions)

Admitted Assets	1991	1990	1986	1981
Total	$920.9	$870.2	$627.9	$372.7
Percent increase from 1981	147.1%	133.5%	68.5%	---
Type of asset				
Bonds	$398.2	$369.4	$252.5	$142.9
Stocks	31.0	29.1	22.7	15.6
Mortgage loans	188.2	200.0	146.5	105.8
Real estate	27.7	24.9	18.0	10.0
Policy loans/liens	41.5	43.2	40.4	36.5
Short-term holdings	19.9	19.2	15.8	a
Other	214.4	184.4	132.0	61.9

[a] Amounts included with "Other."

Source: New York State Insurance Department

Table 2
TOTAL LIFE INSURANCE IN FORCE
Life Insurance Companies Licensed in New York State
Selected Years, 1981-1991

(dollar amounts in billions)

Class of Business	1991	1990	1986	1981
Total insurance in force	$5,772.5	$5,490.6	$4,046.4	$2,696.3
Percent increase from 1981	114.1%	103.6%	50.1%	---
Ordinary	$2,777.5	$2,702.4	$2,031.9	$1,251.1
Group	2,913.9	2,701.8	1,925.4	1,376.5
Credit	72.8	78.0	79.2	59.1
Industrial	8.3	8.4	9.9	9.6

Source: New York State Insurance Department

Table 3
SOURCE OF INCOME
Life Insurance Companies Licensed in New York State
Selected Years, 1981-1991

(dollar amounts in millions)

Source of Income	1991 Amount	1991 Percent of Total	1986 Amount	1986 Percent of Total	1981 Amount	1981 Percent of Total
Total	$217,119.2	100.0%	$160,691.7	100.0%	$82,545.0	100.0%
Premiums, group life	9,002.7	4.1	7,203.7	4.5	6,099.8	7.4
Premiums, group annuities	57,808.2	26.6	45,379.6	28.2	10,907.4	13.2
Premiums, accident & health	28,588.7	13.2	18,777.6	11.7	17,682.3	21.4
Other premiums	51,142.7	23.5	36,748.5	22.9	22,899.8	27.7
Supplementary contracts	4,885.3	2.3	3,124.3	2.0	2,183.1	2.6
Net investment income	61,222.5	28.2	45,059.6	28.0	25,241.1	30.6
Other income	4,469.1	2.1	4,398.4	2.7	-2,468.5*	-2.9

* The negative figure for 1981 is the result of reinsurance.

Source: New York State Insurance Department

Table 4
LIFE INSURANCE IN FORCE IN THE STATE OF NEW YORK
Life Insurance Companies Licensed in New York State
Selected Years, 1981-1991

(dollar amounts in billions)

Insurance In Force	1991	1990	1986	1981
Total	$702.1	$658.5	$485.5	$275.6
Percent increase from 1981	154.8%	138.9%	76.2%	---
Class of business				
Ordinary	$388.2	$371.0	$247.1	$124.7
Group	300.0	272.0	221.4	140.8
Credit	12.9	14.4	15.9	9.0
Industrial	1.0	1.1	1.1	1.1

Source: New York State Insurance Department

Table 5
DOMESTIC LIFE INSURANCE COMPANIES
Selected Years, 1981-1991

(dollar amounts in billions)

Domestic Life Companies	1991	1990	1981
Admitted assets	$329.5	$312.8	$142.5
Percent increase from 1981	131.2%	119.5%	---
Insurance in force	$2,214.2	$2,029.9	$988.7
Percent increase from 1981	124.0%	105.3%	---

Source: New York State Insurance Department

Table 6
SAVINGS BANK LIFE INSURANCE
NEW YORK STATE
Selected Years
1982-1992

(dollar amounts in millions)

SBLI	1992	1991	1987	1982
Number of issuing banks	35	39	48	53
Ordinary insurance issued during year:				
Policies	17,193	17,324	22,072	33,731
Amount	$479.5	$471.9	$508.0	$482.2
Ordinary insurance in force end of year:				
Policies	447,421	454,990	482,544	497,895
Amount	$5,873.5	$5,777.7	$5,569.2	$5,007.2
Group life insurance in force end of year:				
Amount	$15,404.1	$12,247.1	$7,805.8	$4,548.9
Total admitted assets	$997.3	$933.0	$744.3	$553.2

Source: New York State Insurance Department

5. Licensed Fraternal Benefit Societies

Fifty fraternal benefit societies were licensed to do an insurance business in New York State as of December 31, 1992. Eight were domestic societies, 41 were foreign societies and one was an alien society. The total admitted assets held by licensed societies increased by 220% since December 31, 1981, amounting to $29.4 billion at December 31, 1991. During the ten-year period, insurance in force increased by $118.3 billion, amounting to $174.6 billion at December 31, 1991.

6. Private Retirement Systems

At the close of 1991, five private retirement systems were under the supervision of the Insurance Department.

The five systems, which are private pension funds of certain nonprofit organizations, were made subject to Insurance Department regulation by special legislative enactments. At the end of 1991, the assets of these private pension funds totaled approximately $51.2 billion. The following table shows data for these pension funds for selected years from 1981 to 1991:

Table 7
PRIVATE PENSION FUNDS
REGULATED BY INSURANCE DEPARTMENT
Selected Years, 1981-1991

(in millions)

Private Pension Funds	1991	1990	1986	1981
Total admitted assets	$51,241.3	$40,240.7	$27,684.1	$10,261.7
Payments to annuitants and beneficiaries	$2,017.4	$1,676.0	$ 1,399.9	$257.2

Source: New York State Insurance Department

7. Public Retirement Systems

The eight actuarially funded public retirement systems under the supervision of the Insurance Department at the close of 1991 are governmental systems that provide retirement, death and disability benefits to the employees of New York State and those of its political subdivisions that have elected to provide such benefits for their employees. The aggregate assets of the eight governmental systems as of the end of their respective fiscal years ending in 1991 were approximately $125 billion. During the period from 1981 to 1991, the assets of these retirement systems increased at the compound rate of 12.5% per year.

The governmental retirement systems cover a total of 1.7 million active and retired members. The number of active employees in the public retirement systems in 1991 increased by 9% over its 1981 level, while the number of retired employees increased by 45% in the same period. This points up the need for the maintenance of adequate actuarial reserves.

The New York City Administrative Code provides for eight non-pension funds known as variable supplements funds. They are financed by the transfer of earnings from the equity portfolios of the New York City Police and Fire departments' Pension Funds, and the New York City Employees' Retirement System. The variable supplements funds provide retirement benefits in addition to those received from the pension funds, and are under the supervision of the Insurance Department. The assets of the variable supplements funds totaled $1.1 billion as of June 30, 1991, up 10% from last year. As a result of an agreement between New York City and certain of the Police and Fire unions, there will be no further transfers of investment earnings for those unions, but instead the City will guarantee the additional pensions on a graduated scale up to a maximum of $12,000 per annum. The superior officers in both the Police and Fire departments will continue under the variable supplements plans.

The following table shows data for the public employee retirement systems, excluding the variable supplements funds, for selected years from 1981 to 1991:

Table 8
PUBLIC RETIREMENT SYSTEMS AND PENSION FUNDS
REGULATED BY INSURANCE DEPARTMENT
Selected Years, 1981-1991

(in millions)

Public Retirement Systems and Pension Funds	1991	1990	1986	1981
Total admitted assets	$124,912.9	$117,798.4	$78,322.2	$38,343.8
Payments to annuitants and beneficiaries	$6,063.6	$5,411.3	$3,871.8	$2,419.4

Source: New York State Insurance Department

8. Segregated Gift Annuity Funds for Charitable Organizations

Fifty-seven charitable annuity societies held permits under Section 1110 of the Insurance Law at the end of 1991. In return for, or conditioned upon, the receipt of gift funds, such organizations agree to pay an annuity to the donor, or a nominee. These agreements must provide to the issuer, upon the death of the annuitant, a residue equal to at least one-half the original gift or other consideration for such annuity. In the past ten years, admitted assets of these funds increased by 84.2% and the annual payments increased by 115.1%.

Table 9
SEGREGATED GIFT ANNUITY FUNDS
Selected Years, 1981-1991

(in millions)

Segregated Gift Annuity Funds	1991	1990	1986	1981
Total admitted assets	$185.5	$161.1	$123.6	$100.7
Annual payments to annuitants	$15.7	$14.4	$ 10.2	$7.3

Source: New York State Insurance Department

9. Employee Welfare Funds

Twenty-three employee welfare funds covering 112,981 employees were supervised by the Department at the close of 1991. These funds are jointly administered by management and labor representatives. The employee welfare funds cover government employees for benefits financed by contributions from New York governmental authorities. Government employee welfare funds were not pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA).

Contributions to employee welfare funds amounted to $172.8 million in 1991. Benefits paid totaled $181.3 million and included life insurance; medical, surgical and hospital coverage; major medical coverage; optical, dental and prescription drug plans; disability insurance, and legal services. Administrative expenses totaled $10.4 million representing 6.0% of contributions and 5.7% of benefits.

10. Examinations of Insurers Conducted in 1992

Table 10
EXAMINATIONS CONDUCTED BY THE LIFE INSURANCE
AND COMPANIES BUREAU
1992

		Regularly Scheduled Initiated		Other		
	Total	In 1992	Prior to 1992	Special	On organization	Increase in capital and other
Total	41	39	0	0	2	0
Life insurance companies	23	21	0	0	2	0
Life insurance departments of mutual savings banks	6	6	0	0	0	0
Fraternal benefit societies	3	3	0	0	0	0
Retirement systems and pension funds	4	4	0	0	0	0
Segregated gift annuity funds of charitable organizations	5	5	0	0	0	0
Welfare funds	0	0	0	0	0	0

11. Auditing of Financial Statements

a. Audit and Analysis

As of December 31, 1992, 354 companies licensed to do business in New York State, as detailed below, were required to file their 1992 Annual Statements for audit and analysis:

Life - NY	88
Life - Other States	56
Fraternals - NY	8
Fraternals - Other States	41
Fraternals-Canadian, U.S.Branch	1
Accredited Reinsurers	76
Charitable Annuities	63
Retirement Systems	21
	354

In addition to a financial analysis, which includes, but is not limited to, solvency, investment portfolio, reinsurance, etc., the annual statements are audited for overall integrity; compliance with NAIC requirements for completing the blank; compliance with Department statutes, regulations and rules. Questions that arose during the audits were resolved with the companies.

The Bureau revised the computer crosschecks used in the audit of the life and accident and health, separate account and fraternal benefit society annual statements to reflect changes in the blanks and to meet current needs and requirements. The computer crosschecks for the New York Supplement to the life and accident and health annual statement were revised and expanded in preparation for the diskette, which was optional for the 1991 Annual Statement but will be mandatory for the 1992 filing.

The revised instructions were provided to the Insurance Regulatory Systems Bureau to enable that Bureau to prepare the crosschecks.

As a result of the audits of the 1991 annual statements, some filed statements were adjusted to bring reported figures into compliance with New York requirements. The adjustments resulted in a change of surplus for 25 companies. The total changes resulted in a net decrease in surplus in the amount of $211,979,297. Changes were made for the following reasons:

Unauthorized reinsurance	($199,948,543)
Ineligible assets	(1,022,017)
Miscellaneous	(11,008,737)
Total	($211,979,297)

b. New York Supplements to the Annual Statements

New York Supplements to the life and accident and health annual statement and the fraternal benefit society annual statement were developed for use beginning with the 1986 Annual Statement filing.

The Supplements for 1992 were updated to meet current needs and requirements. Copies of the supplements were furnished to the printer, Brandon Insurance Service, and copies were distributed to all life companies and fraternal benefit societies licensed to do business in New York State.

c. Valuations of Securities

In most instances, this Department adheres to rules promulgated by the National Association of Insurance Commissioners (NAIC) in its Book of Valuations of Securities, pertaining to the valuation of bonds and stocks reported in the annual statement.

Valuations were calculated for the capital stock of 182 insurance company subsidiaries and 476 non-insurance subsidiaries. Valuations were also computed for 17 insurance company bonds and 166 non-insurance subsidiary bonds. Where applicable, the respective annual statements were revised to properly reflect the not-admitted assets and the corresponding reduction in surplus.

The bonds reported by all licensed insurers were reviewed to determine amortizability and market value. The accuracy of market values reported for preferred and common stocks listed in the annual statements were verified.

d. Public Inspection of Records

The Bureau provides public access to various Insurance Department documents and insurance related materials. In 1992, 111 members of the public reviewed 578 annual statements, 260 quarterly statements and 20 Reports on Examination. Information was also made available from such source materials as the NAIC Book of Valuations of Securities and Best's Insurance Reports

12. Real Estate Review

During 1992, the Real Estate Section of the Life Insurance and Companies Bureau reviewed original appraisals supporting real estate investments held by companies under examination. Field inspections were conducted of 312 properties having an aggregate book value of $4,036,805,200.

Six projects involving home- or branch-office acquisition or new construction were approved in the amount of $149,825,000.

Other activities included the review and approval of mortgage loans to officers, leases within holding company systems, and home-office and leasehold improvement costs. Recommendations were also made relating to property valuation and the transfer of assets.

13. Actuarial Submissions and Reviews

Submissions made by various life insurance companies for approval of redistributed commission scales, persistency production bonus plans, expense allowance plans, training allowance plans, and other forms of agent compensation were reviewed by the Bureau's staff.

The Bureau's actuaries are also participating with a representative industry committee in continuing efforts to revamp Section 4228 of the Insurance Law, the basic part of the Law governing agent compensation.

In addition, the actuaries provide ongoing support to the Agency, Product Regulation and Administration Unit which has been conducting audits of the agency operations of non-domestic companies.

14. Agency Operations Unit

The Life Bureau's Agency Operations Unit conducts examinations of the operations of foreign life insurance companies. These agency audits deal primarily with the levels of compensation paid to a company's sales force, such as commissions, expense allowances and training subsidies, etc., which are restricted by Section 4228 of the New York Insurance Law. Domestic insurers are routinely audited for compliance with Section 4228 as part of the regular statutory examinations conducted by the Bureau. The focus of these examinations is to produce a level playing field among domestic and foreign life insurers by assuring that foreign insurers are conducting their agency operations in compliance with New York Insurance Law and regulations.

The examinations that were conducted in 1992, one of which has continued into 1993, have indicated a wide range of violations of Section 4228. These audits have revealed improper payments to agents and excessive expenses of agency conferences. As a result of these initial findings, examiners will be assigned to perform additional agency audits of foreign insurers during 1993.

15. Public Retirement Systems Legislation

During 1992, 55 separate pieces of legislation that impacted on the public retirement systems in varying degrees were enacted into law. Approximately one-third of these were special interest bills, each affecting a single individual. Two pieces of legislation provided incentive retirement options and the remainder were bills chiefly limited to certain categories of members.

The actuarial structure of the eight public retirement systems remained unchanged during the 1992 legislative session, following the radical changes effected by the 1990 and 1991 enactments.

16. Financial Indicators

Bureau representatives are continually developing and testing financial indicators that lead to the early detection of potentially troubled companies. One such indicator, the New York Risk Adjusted Capital Ratio (NYRACR), was developed to provide early detection of potential problems in companies licensed in the State of New York. The NYRACR, as with any financial analytical tool, requires refinements to reflect the current changes in the life insurance industry.

A risk-based capital formula and model act was developed by the National Association of Insurance Commissioners Risk-Based Capital Working Group, which is chaired by New York. The formula and model act, adopted by the NAIC in December 1992, will be utilized by regulators for monitoring the financial condition of life and accident and health insurance companies.

New York also chaired an NAIC working group that developed asset-based valuation reserves (Asset Valuation Reserve and Interest Maintenance Reserve) implemented December 31, 1992.

17. National Association of Insurance Commissioners (NAIC)

The Life Insurance and Companies Bureau provided a representative to participate in the NAIC Examiner Team Project. The Bureau's representative served as Assistant Project Director. The Examiner Team analyzes Annual Statements and Insurance Regulatory Information System (IRIS) results of all participating companies to determine the degree of regulatory attention required.

18. Equitable Life Demutualization

On July 22, 1992, The Equitable Life Assurance Society of the United States became the first insurer to demutualize under New York's 1988 demutualization statute for life insurers. The Equitable is the largest life insurer in the United States to convert its form of organization.

The reorganization plan was adopted by Equitable's board of directors in November 1991 and submitted to the Superintendent in December 1991. A public hearing was held in April 1992 on the fairness of the terms and conditions of the plan, the reasons and purposes for Equitable to demutualize, and whether the reorganization was in the interests of Equitable and its policyholders and not detrimental to the public. Equitable received approval of its demutualization plan from 92.3% of the 888,338 policyholders who cast ballots. The Superintendent approved the plan in May 1992.

The demutualization process was completed when Equitable concluded its initial public offering of common stock. Fifty million shares of common stock were sold at $9 per share. At the same time, a $1 billion investment by AXA, a French insurer, was converted into common and preferred stock.

Under demutualization, policyholders received common stock, cash or policy credits. Equitable's conversion to a stock company did not change policy benefits, values, premiums or guarantees in any way.

19. Phoenix Mutual - Home Life Merger

The first merger of two major mutual life insurers, Phoenix Mutual Life Insurance Company and Home Life Insurance Company, was completed on July 1, 1992 after the Superintendent formally approved the plan in mid-June. The merged company, known as Phoenix Home Life Mutual Insurance Company, has nearly $11 billion in assets. As a result of the merger, Phoenix Home expects to realize annualized cost savings of $70 million.

Prior to the merger Phoenix Mutual Life Insurance Company, a Connecticut domiciled company, became the first insurer to redomesticate under New York's 1992 redomestication statute which permits authorized foreign life insurers to transfer their corporate domicile to this State. Phoenix Mutual's redomestication from Connecticut to New York became effective July 1, 1992.

20. Mutual Benefit Life Insurance Company

Mutual Benefit Life Insurance Company, a mutual life insurer domiciled in New Jersey and licensed in all 50 states, was placed in rehabilitation by the New Jersey Insurance Department on July 16, 1991. New York policyholders comprise the largest block of policyholders with over 16% of the company's $13 billion in liabilities.

New York Superintendent of Insurance Salvatore R. Curiale initially resisted the New Jersey Plan as inconsistent with New York statutory guarantees. Under New York Law, the Life Insurance Company Guaranty Corporation of New York (Guaranty Corporation) is not permitted to become a participating guaranty corporation in any out-of-state rehabilitation plan without the New York Superintendent's permission.

As a result of the Superintendent's opposition and his negotiations with the Guaranty Corporation and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), the rehabilitation plan was amended. On January 15, 1993 the Superintendent approved the Guaranty Corporation's participation in the rehabilitation plan as a participating guaranty association.

This approval was subject to the Guaranty Corporation's providing enhancements to New York policyholders as outlined in a Memorandum of Understanding. The Memorandum of Understanding details the enhancements which relate to liquidity, interest rates, coverage and assurance of payments.

The Plan of Rehabilitation was submitted to New Jersey Superior Court for approval in January 1993.

B. PROPERTY COMPANIES BUREAU

1. Entities Under Property Companies Bureau Supervision

The Property Companies Bureau had regulatory authority over 1,455 insurer and non-insurer entities as of December 31, 1992.

The Bureau regulated 834 insurer entities, comprised of:

17 Accident and health insurers;
43 Accredited reinsurers;
20 Advance premium co-operatives;
34 Assessment co-operatives;
12 Financial guaranty insurers;
46 Health insurance corporations;*
12 Joint underwriting associations;
7 Medical malpractice companies;
1 Medical Malpractice Insurance Association;
12 Mortgage guaranty insurers;
4 New York Insurance Exchange members;
1 New York Property Insurers Underwriting Association (FAIR Plan);
606 Property/casualty companies; and
19 Title insurers.

The Bureau oversaw the operation of 45 risk retention groups in 1992. It supervised 297 reinsurance intermediaries and 12 insurer controlling producers and also oversaw 267 managing general agent filings.

The Property Companies Bureau received 28 applications for licensing and six applications for accreditation during 1992. Ten stock insurers were newly licensed, including two domestic companies, one foreign title insurer and one foreign mortgage guaranty insurer; one stock insurer was accredited. At the close of the year, 14 domestic stock companies and 29 foreign stock companies were in the process of completing licensure with the Department and 12 applications for accreditation were still outstanding.

During 1992, two accredited reinsurers withdrew from New York, with one becoming a licensed foreign insurer. One New York stock insurer had its license revoked.

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*The health insurance corporations included 15 health, hospital service, medical and dental expense indemnity corporations, two Article 43 of the Insurance Law health maintenance organizations (HMOs) and 29 Article 44 of the Public Health Law HMOs.

2. Property and Casualty Business

a. Premium Volume and Surplus to Policyholders

Net premiums written during 1991 by all New York licensed property and casualty insurers aggregated $171,652 million of which 71% represents stock company writings. The following discussion of underwriting and investment results deals with the countrywide business of New York-licensed companies:*

Table 11
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS
Property and Casualty Insurers Licensed in New York State
1981-1991[a]

(dollar amounts in millions)

	Stock Companies			Mutual Companies		
Year	Net Premiums Written (during year)	Surplus/ Policyholders (end of year)	Ratio of Premiums to Surplus	Net Premiums Written (during year)	Surplus/ Policyholders (end of year)	Ratio of Premiums to Surplus
1981	$ 58,159	$33,030	1.8	$20,327	$13,954	1.5
1982	60,442	36,384	1.7	21,630	16,094	1.3
1983	62,751	37,753	1.7	23,296	18,427	1.3
1984	67,821	35,856	1.9	25,915	18,721	1.4
1985	83,780	43,564	1.9	31,167	20,999	1.5
1986	102,376	57,664	1.8	36,260	25,354	1.4
1987	111,831	63,299	1.7	39,675	28,035	1.4
1988	115,213	72,612	1.6	42,033	30,569	1.4
1989	114,970	78,546	1.5	49,062	35,552	1.4
1990	119,042	80,451	1.5	47,336	35,596	1.3
1991	121,660	92,803	1.3	49,992	40,186	1.2

[a] Not adjusted for prepaid acquisition costs. Surplus includes gains or losses from unrealized appreciation or depreciation in value of stock.

Source: New York State Insurance Department

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*Unless otherwise noted, tables and related data refer to the nationwide operations of insurers authorized to do business in this State and include insurers whose principal business is accident and health. Data for stock insurers includes United States branches of alien insurers. Data for mutual insurers includes the State Insurance Fund, Lloyds Underwriters, the Medical Malpractice Insurance Association and reciprocals. Data for medical malpractice companies is included with the data for stock insurers or mutual insurers, as appropriate. Data for mortgage guaranty insurers, title insurers, co-operative fire insurers, financial guaranty insurers, and New York Insurance Law Article 43 and Public Health Law Article 44 corporations is summarized separately.

b. Underwriting Results

Results for 1991 show a net underwriting loss of $11,804 million for stock companies and $2,512 million for mutual companies. For 1990, stock companies showed a net underwriting loss of $11,437 million while mutual companies experienced a net loss of $4,013 million.

Table 12
UNDERWRITING RESULTS
Property and Casualty Insurers Licensed in New York State*
1986-1991

(dollar amounts in millions)

		Stock Companies		Mutual Companies	
Year		Number of Companies	Amount	Number of Companies	Amount
1986	Underwriting gains	84	$ 363.7	19	$ 473.4
	Underwriting losses	350	8,709.6	66	2,661.0
	No gain or loss	24	---	--	---
1987	Underwriting gains	134	$ 1,256.9	27	$ 451.5
	Underwriting losses	317	5,908.8	57	2,001.8
	No gain or loss	23	---	--	---
1988	Underwriting gains	143	$ 1,079.2	34	$ 439.6
	Underwriting losses	321	6,388.8	46	2,884.3
	No gain or loss	23	---	--	---
1989	Underwriting gains	92	$ 501.0	11	$ 916.3
	Underwriting losses	380	11,707.2	66	3,667.7
	No gain or loss	21	---	--	---
1990	Underwriting gains	91	$ 461.9	17	$ 155.7
	Underwriting losses	385	11,898.9	62	4,169.1
	No gain or loss	30	---	--	---
1991	Underwriting gains	93	$ 446.0	13	$ 319.7
	Underwriting losses	406	12,249.9	66	2,831.3
	No gain or loss	27	---	--	---

*Excludes companies whose principal business is accident and health.

Source: New York State Insurance Department

c. Investment Income and Capital Gains

Investment income and net capital gains for stock and mutual companies from 1986 to 1991 are as follows:

Table 13
INVESTMENT INCOME AND CAPITAL GAINS
Property and Casualty Insurers Licensed in New York State
1986-1991

(in millions)

Year		Stock Companies	Mutual Companies
1986	Net investment income	$13,310.6	$4,304.6
	Realized capital gains	3,979.1	1,384.2
	Unrealized capital gains	1,802.6	1,748.6
	Net gain from investments	$19,092.3	$7,437.4
1987	Net investment income	$14,824.5	$4,786.3
	Realized capital gains	1,904.6	767.8
	Unrealized capital gains	-1,678.5	523.5
	Net gain from investments	$15,050.6	$6,077.6
1988	Net investment income	$17,451.6	$5,147.1
	Realized capital gains	1,615.7	611.0
	Unrealized capital gains	2,619.1	1,454.6
	Net gain from investments	$21,686.4	$7,212.7
1989	Net investment income	$19,058.2	$5,713.9
	Realized capital gains	3,542.3	542.7
	Unrealized capital gains	3,367.9	2,798.7
	Net gain from investments	$25,968.4	$9,055.3
1990	Net investment income	$19,111.3	$6,123.6
	Realized capital gains	2,118.6	369.1
	Unrealized capital gains	-3,171.0	-990.5
	Net gain from investments	$18,058.9	$5,502.2
1991	Net investment income	$20,960.7	$6,576.2
	Realized capital gains	2,961.5	590.1
	Unrealized capital gains	7,140.2	3,919.3
	Net gain from investments	$31,062.4	$11,085.6

Source: New York State Insurance Department

d. Underwriting and Investment Exhibit

During 1991, dividends to stockholders amounted to $6,329 million; for the same period, dividends to policyholders aggregated to $2,113 million. The aggregate contribution to surplus for 1991 was $3,420 million compared with $3,263 million for 1990.

Table 14
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT[a]
Property and Casualty Insurers Licensed in New York State
1990 and 1991

(in millions)

	1991		1990	
	Stock Companies	Mutual Companies	Stock Companies	Mutual Companies
Net gain or loss from:				
Underwriting	$-11,803.9	$-2,511.6	$-11,437.0	$-4,013.4
Investments	23,899.9	6,945.6	21,209.5	6,287.6
Other income	-699.0	-125.6	-352.2	-72.8
Net gain or loss	$ 11,397.0	$ 4,308.4	$ 9,420.3	$ 2,201.4
Less:				
Dividends to policyholders	1,087.8	1,025.1	1,140.5	822.5
Federal income taxes incurred	1,976.9	738.2	1,615.4	450.7
Net income	$ 8,332.3	$ 2,545.1	$ 6,664.4	$ 928.2
Surplus changes other than net income:				
Dividends to stockholders				
- Cash	$ -6,118.4	$ ---	$ -4,882.2	$ ---
- Stock	-210.4	---	-7.2	---
Net remittance to/from home office	-34.0	---	-152.6	---
Total dividends and remittance	$ -6,362.8	$ ---	$ -5,042.0	$ ---
Unrealized capital gains	7,139.9	3,977.2	-3,170.9	-947.3
Changes in statutory over case basis	136.8	20.2	198.7	161.6
Miscellaneous items	-1,405.8	-2,094.0	218.9	-232.6
Contributions to surplus	3,418.4	2.0	3,257.2	5.3
Total other sources	$ 2,926.5	$ 1,905.4	$ -4,538.1	$-1,013.0
Net increase or decrease in surplus	$11,258.8	$4,450.5	$ 2,126.3	$ -84.8

[a] Not adjusted for prepaid acquisition costs. Excludes insurers whose principal business is accident and health.

Source: New York State Insurance Department

Table 15
PERCENT DISTRIBUTION OF INVESTMENTS
Property and Casualty Insurers Licensed in New York State
Selected Years, 1981-1991

	1991	1990	1989	1988	1987	1986	1981
				Stock Companies			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bonds	70.9	69.5	68.8	68.6	68.9	67.0	69.4
Stocks	20.9	20.1	21.9	21.0	21.4	23.1	28.6
Mortgage loans	1.9	2.2	2.2	2.0	2.0	2.1	1.0
Real estate	1.1	1.1	0.9	0.9	0.8	0.8	1.0
Short term	5.2	7.1	6.2	7.5	6.9	7.0	---
				Mutual Companies			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bonds	66.4	68.1	65.8	68.5	67.8	67.0	71.3
Stocks	28.8	26.7	28.2	26.6	25.8	26.5	26.2
Mortgage loans	0.3	0.2	0.1	0.1	0.2	0.2	0.3
Real estate	2.6	2.6	2.3	2.2	2.1	2.0	2.2
Short term	1.9	2.4	3.6	2.6	4.1	4.3	---

Source: New York State Insurance Department

e. Property and Casualty Companies

From 1981 to 1991, aggregate net premiums written increased 119%; admitted assets rose 170%; unearned premium and loss reserves increased 169%; and other liabilities increased 142%. Capital and surplus to policyholders increased by 183%.

Table 16
SELECTED ANNUAL STATEMENT DATA
Property/Casualty Insurers Licensed In New York State
Selected Years, 1981-1991

(dollar amounts in millions)

	1991	1990	1989	1986	1981
			Stock Companies		
Number of insurers	539	519	505	469	436
Net premiums written	$121,660	$119,042	$114,970	$102,376	$ 58,159
Admitted assets	361,968	336,975	297,376	232,047	135,216
Unearned premium & loss reserves	240,116	226,422	213,101	157,368	89,315
Other liabilities	29,050	26,610	25,529	17,016	12,871
Capital	2,658	2,051	1,989	1,761	1,581
Surplus funds	90,144	78,400	75,557	55,903	31,449
			Mutual Companies		
Number of insurers	83	83	83	89	89
Net premiums written	$ 49,992	$ 47,336	$49,062	$36,260	$20,327
Admitted assets	124,416	112,365	106,299	77,897	44,734
Unearned premium & loss reserves	74,274	69,236	63,619	46,862	27,538
Other liabilities	9,956	7,533	7,128	5,681	3,242
Surplus to policyholders	40,186	35,596	35,552	25,354	13,954

Source: New York State Insurance Department

f. Audit and Analysis

The 1991 annual statements of the companies authorized to transact business in the State of New York were filed in 1992 for audit and analysis, as were those of reinsurers accredited in this State. Questions arising during the audits were resolved with the companies. As a result of the audits, some filed statements were adjusted to bring reported figures into compliance with New York requirements.

There were 2,300 quarterly statements filed with the Property Companies Bureau during 1992.

All property/casualty insurers are required to file a loss reserve development schedule as part of each quarterly statement; insurers licensed pursuant to Section 6302 are also required to file a supplemental schedule of special risks. Quarterly statements were reviewed to verify that all required schedules were properly filed.

g. Valuations of Securities

In most instances, the Property Companies Bureau utilizes the rules promulgated in the National Association of Insurance Commissioners' Book of Valuations of Securities with respect to valuations of bonds and stocks for annual-statement purposes.

Valuations were calculated to ascertain if any adjustments to surplus to policyholders of 331 licensed insurers were necessary with respect to shares they held in 808 insurers and 566 non-insurance subsidiaries. A total of 1,374 separate valuations were developed during 1992. Where applicable, the respective annual statements were revised to properly reflect the not-admitted assets and the corresponding reduction in surplus.

The bonds reported by all licensed insurers were reviewed to determine amortizability and marketability. The accuracy of the market values for preferred and common stock listed in the annual statements was also verified.

h. State Insurance Fund

All purchases and sales of bonds by the State Insurance Fund are subject to the approval of the Superintendent. Upon review, the Property Companies Bureau recommended the approval of acquisitions totaling $1,243 million and sales totaling $319 million during 1992. In 1991, the Bureau recommended approval of acquisitions totaling $2,900.5 million and sales totaling $399.3 million.

i. CPA-Audited Financial Statements

Section 307(b) of the New York Insurance Law requires licensed insurers to file an annual financial statement certified by an independent certified public accountant (CPA) on or before June 30 each year. CPA-audited financial statements were received and reviewed for 726 companies. There were 16 companies entitled to exemption from the filing requirements.

j. Public Inspection of Records

The Property Companies Bureau provides public access to various Insurance Department documents and insurance-related materials pursuant to the Freedom of Information Law (FOIL). In 1992, there were 299 FOIL requests received from members of the public to review and copy records maintained by the Bureau.

k. Holding Company-Related Transactions

Pursuant to Article 15 and Department Regulation 52, the Property Companies Bureau is responsible for the review and approval of transactions within holding company systems. During 1992, 290 transactions were reviewed and approved by the Bureau. These included, but were not limited to, 115 reinsurance agreements, 43 management or service agreements, one notice of acquisition of control of insurers, and eight requests for sales, purchases or transfers of assets.

3. Mortgage Guaranty Insurance

One domestic and eleven foreign companies were licensed to transact mortgage guaranty business in New York at year-end 1991.

Table 17
SELECTED ANNUAL STATEMENT DATA
Mortgage Guaranty Insurers
Selected Years, 1986-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1986
Number of companies	12	11	11	11	12
Net premiums written	$ 938.0	$ 804.3	$ 696.1	$ 663	$ 0.6
Assets	4,035.2	3,491.4	3,218.6	2,992	3,075
Liabilities	2,508.0	2,072.1	1,769.7	1,616	1,883
Capital and surplus	1,527.2	1,419.3	1,448.9	1,376	1,192

Source: New York State Insurance Department

Table 18
PERCENT DISTRIBUTION OF ASSETS
Mortgage Guaranty Insurers
1988-1991

	1991	1990	1989	1988
Total	100.0%	100.0%	100.0%	100.0%
Bonds	78.5	73.0	75.3	69.8
Stocks	9.8	9.5	8.7	7.9
Mortgage loans	0.5	0.6	0.7	0.5
Real estate	1.3	1.7	2.3	2.8
Short term	5.6	9.8	7.2	10.5
Cash	-0.1	0.2	-0.4	-0.2
Premiums and fees receivable	--	-0.1	-0.1	-0.3
Other assets	4.4	5.3	6.4	9.1

Source: New York State Insurance Department

4. Title Insurance

Nine domestic and ten foreign companies were licensed to write title insurance in this State at the close of 1991. The statutory reinsurance reserve of title insurers authorized in this State approximated $671 million as of December 31, 1991, of which domestic insurers had $53 million.

Table 19
SELECTED ANNUAL STATEMENT DATA
Domestic Title Insurance Companies
Selected Years, 1981-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1986	1981
Number of Companies	9	8	10	8	7	8
Net premiums written	$177.9	$169.2	$182.0	$205.0	$192.7	$47.4
Admitted assets	183.1	184.0	$193.3	181.1	$142.6	$80.1
Liabilities	91.4	85.5	75.0	71.0	70.0	38.7
Capital	9.1	8.9	8.6	8.6	7.5	6.8
Surplus	82.6	89.6	109.7	101.5	65.1	34.6
Surplus to policyholders	91.7	98.5	118.3	110.1	72.6	41.4

Source: New York State Insurance Department

Table 20
PERCENT DISTRIBUTION OF ASSETS
Domestic Title Insurance Companies
Selected Years, 1981-1991

	1991	1990	1989	1988	1986	1981
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bonds	64.3	67.3	37.4	36.6	31.3	40.3
Stocks*	2.8	2.4	3.5	3.3	2.6	0.1
Mortgage loans	4.7	3.8	0.7	0.8	3.0	32.3
Real estate	2.0	1.6	1.4	1.3	1.3	0.4
Cash	9.9	17.7	52.2	53.2	54.9	23.1
Premiums and fees receivable	1.7	1.5	2.0	2.1	4.4	1.5
Other assets	14.6	5.7	2.8	2.7	2.5	2.3

* Includes investment in savings and loan associations.

Source: New York State Insurance Department

5. Advance Premium and Assessment Co-Operatives

At year-end 1992, there were 20 advance premium companies and 34 assessment co-operative companies under the Property Companies Bureau's supervision. During 1992, examinations of 15 companies were conducted.

The total number of assessment co-operative companies decreased by one during 1991, due to a merger, and the net premium volume of such companies decreased by 1%. During this period, the number of advance premium companies remained the same and the net premium volume of such companies increased by 9%.

Table 21
SELECTED ANNUAL STATEMENT DATA
Advance Premium and Assessment Co-Operative Companies
New York State
1986-1991

(dollar amounts in millions)

	Total	Advance Premium Companies	Assessment Co-Operative Companies
1986			
Number of companies	66	19	47
Total assets	$397.5	$296.8	$100.7
Net premiums written	206.3	172.9	33.4
Surplus funds	176.4	106.4	70.0
1987			
Number of companies	61	19	42
Total assets	$453.2	$347.5	$105.7
Net premiums written	255.6	210.9	44.7
Surplus funds	187.8	118.3	69.5[r]
1988			
Number of companies	59	19	40
Total assets	$523.2	$404.4	$118.8
Net premiums written	287.9	238.0	49.9
Surplus funds	211.4	138.1	73.3
1989			
Number of companies	59	19	40
Total assets	$585.6	$457.0	$128.6
Net premiums written	303.7	253.8	49.9
Surplus funds	237.9	160.3	77.6
1990			
Number of companies	57	20	37
Total assets	$648.4	$512.4	$136.0
Net premiums written	346.1	293.0	53.1
Surplus funds	251.4	169.8	81.6
1991			
Number of companies	56	20	36
Total assets	$715.8	$571.8	$144.0
Net premiums written	372.3	319.8	52.5
Surplus funds	272.8	185.1	87.7

[r] Revised

Source: New York State Insurance Department

6. Financial Guaranty Insurance

Article 69 of the New York Insurance Law made financial guaranty insurance a separate kind of insurance effective May 14, 1989.

Section 1113(a) was amended to add paragraph 25, "Financial Guaranty Insurance." Financial guaranty insurance, briefly, is a surety bond, insurance policy, indemnity contract or similar guaranty under which loss is payable upon proof of occurrence of financial loss.

Permissible guaranties include the failure of any obligor on any debt instrument to pay when due, principal, interest, premium, dividend or purchase price when such failure is the result of a financial default or insolvency in the following categories:

- asset-backed securities;
- consumer debt obligations;
- corporate obligations;
- industrial development bonds;
- installment purchase agreements;
- municipal obligation bonds;
- partnership obligations;
- special revenue bonds; and
- utility first mortgage obligations.

Financial guaranty insurance may be written only by an insurer empowered to write financial guaranty business as described in Section 1113(a) of the Insurance Law. Property/casualty insurers cannot be empowered or licensed to transact financial guaranty insurance; however, property/casualty insurers that had been writing financial guaranty insurance prior to the implementation of Article 69 must conform to the applicable transition rules set forth in Section 6907 of the Insurance Law. Dependent upon their surplus to policyholders, property/casualty insurers may continue to write financial guaranty coverages for periods of nine months, one year, five years or eight years from the effective date of Article 69.

Financial guaranty insurance had previously been written under the fidelity/surety line of business.

In addition to being licensed for financial guaranty insurance, a financial guaranty insurer may also transact surety insurance [Section 1113(a), paragraph 16,C,D,E and F], credit insurance [Section 1113(a) paragraph 17A] and residual value insurance [Section 1113(a), paragraph 22].

As of December 31, 1992, there were six domestic and six foreign financial guaranty insurers licensed in New York.

Each financial guaranty insurer is required to maintain a surplus to policyholders of $65 million. If also licensed to write paragraphs 16(C,D,E and F), 17(A) and/or 22 of Section 1113(a), the financial guaranty insurer is required to maintain additional surplus for these lines in accordance with the provisions of Section 4103.

Table 22
NET PREMIUMS WRITTEN AND SURPLUS TO POLICYHOLDERS[a]
Financial Guaranty Insurers Licensed in New York State
1989-1991

(dollar amounts in millions)

Year	Net Premiums Written (during year)	Surplus to Policyholders (end of year)	Ratio of Premiums to Surplus
		Domestic Companies	
1989	$286.3	$1,404.1	0.20
1990*	553.4	1,711.4	0.32
1991	478.0	1,986.5	0.24
		Foreign Companies	
1989	$153.7	$927.0	0.17
1990*	2.4	879.7	†
1991	180.8	1,003.3	0.18
		Total	
1989	$440.0	$2,331.1	0.19
1990	555.8	2,591.1	0.21
1991	658.5	2,989.8	0.22

[a] Not adjusted for prepaid acquisition costs. Includes gains or losses from unrealized appreciation or depreciation in value of stock.

*In January 1990, Municipal Bond Investors Assurance Corporation (MBIA CORP.), a domestic insurer, acquired all the outstanding shares of MBIA Insurance Corporation of Illinois (MBIA Illinois). MBIA Corp. assumed $157.7 million of net premiums written from MBIA Illinois.

†Less than 0.05

Source: New York State Insurance Department

Table 23
UNDERWRITING RESULTS
Financial Guaranty Insurers Licensed in New York State
1989-1991
(dollar amounts in millions)

	Total		Domestic Companies		Foreign Companies	
	Number	Amount	Number	Amount	Number	Amount
1989						
Underwriting gains	2	$ 41.3	1	$29.7	1	$11.6
Underwriting losses	9	89.0	5	42.2	4	46.8
No gain or loss	--	--	--	--	--	--
1990						
Underwriting gains	3	$ 40.9	3	$40.9	--	$--
Underwriting losses	8	43.4	3	17.4	5	26.0
No gain or loss	--	--	--	--	--	--
1991						
Underwriting gains	6	$115.9	3	$78.2	3	$37.7
Underwriting losses	5	22.2	3	13.0	2	9.2
No gain or loss	--	--	--	--	--	--

Source: New York State Insurance Department

Table 24
INVESTMENT INCOME AND CAPITAL GAINS
Financial Guaranty Insurers Licensed in New York State
1989-1991
(in millions)

	1991	1990	1989
		Domestic Companies	
Net investment income	$278.0	$260.3	$215.8
Realized capital gains	30.7	6.1	9.7
Unrealized capital gains	21.7	-7.3	-0.9
Net gain from investments	$330.4	$259.1	$224.6
		Foreign Companies	
Net investment income	$132.0	$126.6	$141.0
Realized capital gains	17.8	3.1	6.0
Unrealized capital gains	3.7	---	3.0
Net gain from investments	$153.5	$129.7	$150.0
		Total	
Net investment income	$410.0	$386.9	$356.8
Realized capital gains	48.5	9.2	15.7
Unrealized capital gains	25.4	-7.3	2.1
Net gain from investments	$483.9	$388.8	$374.6

Source: New York State Insurance Department

Table 25
AGGREGATE UNDERWRITING AND INVESTMENT EXHIBIT[a]
Financial Guaranty Insurers Licensed in New York State
1989-1991

(in millions)

	1991	1990	1989
Net gain or loss from:			
Underwriting	$ 93.7	$ -2.4	$ -47.7
Investments	458.5	396.0	372.5
Other income	5.3	5.1	4.2
Net gain or loss	$ 557.5	$ 398.7	$ 329.0
Less:			
Dividends to policyholders	---	---	---
Federal income taxes incurred	127.6	84.6	81.7
Net income	$ 429.9	$ 314.1	$ 247.3
Surplus changes other than net income:			
Dividends to stockholders			
- Cash	$ -73.5	$-150.0	$ -86.0
- Stock	---	-5.0	-0.1
Net remittance to/from home office	---	---	---
Total dividends and remittance	$ -73.5	$-155.0	$ -86.1
Changes in statutory over case basis	---	---	---
Miscellaneous sources	-159.4	-133.6	-39.0
Contributions to surplus	205.6	234.5	7.8
Total other sources	$ -27.3	$ -54.1	$-117.3
Net increase or decrease in surplus	$ 402.6	$ 260.0	$ 130.0

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[a] Not adjusted for prepaid acquisition costs. Includes unrealized gains or losses in value of stocks.

Source: New York State Insurance Department

Table 26
PERCENT DISTRIBUTION OF INVESTMENTS
Financial Guaranty Insurers Licensed in New York State
1989-1991

	1991	1990	1989
		Domestic Companies	
Total	100.0%	100.0%	100.0%
Bonds	85.5	87.2	83.7
Stocks	7.2	6.2	3.1
Mortgage loans	--	--	--
Real estate	0.6	0.8	0.7
Short term	6.7	5.8	12.5
		Foreign Companies	
Total	100.0%	100.0%	100.0%
Bonds	89.3	91.1	90.6
Stocks	6.7	3.4	2.6
Mortgage loans	--	--	--
Real estate	--	--	--
Short term	4.0	5.5	6.8
		Total	
Total	100.0%	100.0%	100.0%
Bonds	86.6	88.3	86.3
Stocks	7.1	5.3	2.9
Mortgage loans	--	--	--
Real estate	0.4	0.5	0.4
Short term	5.9	5.9	10.4

Source: New York State Insurance Department

Table 27
SELECTED ANNUAL STATEMENT DATA
Financial Guaranty Insurers Licensed In New York State
1989-1991

(in millions)

	1991	1990	1989
	Domestic Companies		
Exposure	$349,799.0	$291,935.0	$216,100.0
Net premiums written	478.0	553.4	286.3
Admitted assets	4,700.5	4,024.2	3,194.2
Unearned premium & loss reserves	1,978.0	1,734.7	1,348.9
Other liabilities	736.0	578.4	441.2
Capital	18.0	18.0	18.0
Surplus funds	1,968.5	1,693.4	1,386.1
	Foreign Companies		
Exposure	$355,412.0	$108,987.0	$128,800.0
Net premiums written	180.8	2.4	153.7
Admitted assets	2,051.9	1,745.3	1,909.4
Unearned premium & loss reserves	678.2	593.8	687.1
Other liabilities	370.4	271.6	295.4
Capital	110.0	110.0	102.5
Surplus funds	893.3	769.7	824.5
	Total		
Exposure	$705,211.0	$400,922.0	$344,900.0
Net premiums written	658.8	555.8	440.0
Admitted assets	6,752.4	5,769.5	5,103.6
Unearned premium & loss reserves	2,656.2	2,328.5	2,036.0
Other liabilities	1,106.4	850.0	736.6
Capital	128.0	128.0	120.5
Surplus funds	2,861.8	2,463.1	2,210.6

Source: New York State Insurance Department

7. New York Insurance Exchange, Inc.

Effective July 6, 1989, the regulation of the New York Insurance Exchange, Inc. (the Exchange), the NYIE Security Fund, Inc., and the Exchange Underwriting Members was transferred to the Property Companies Bureau.

In November 1987, the Exchange Members voted to suspend writing new and renewal business. No business has been written on the Exchange since that time. As of December 31, 1992, six Underwriting members were in liquidation, one in its domiciliary jurisdiction and five in New York. All but two of the Exchange's Underwriting Members have withdrawn by assumption.

8. Special Risk Insurers (Free Trade Zone)

Calendar year 1992 was the 14th full year of operation for the companies licensed as special risk insurers pursuant to Section 6302 of the Insurance Law. There were 131 licensed companies as of December 31, 1992. Net premiums written during the year amounted to an estimated $317.9 million, bringing the net premiums written since inception to over $2.3 billion.

Net premiums written (in millions) since inception are as follows:

1978 - 1984	$487.3	
1985	151.9	
1986	175.7	
1987	204.6	
1988	230.9	
1989	252.4	
1990	257.7	
1991	306.2	
1992	317.9	(estimated)

9. Risk Retention Groups

On October 27, 1986, the Liability Risk Retention Act of 1986, a significant federal statute affecting the insurance industry, was enacted. Generally, the legislation permits the organization and operation of risk retention groups and purchasing groups for the purpose of providing or obtaining commercial liability insurance coverage.

The Property Companies Bureau regulates risk retention groups. The Property and Casualty Bureau was given the function of regulating purchasing groups.

A risk retention group is an insurance company owned by its members and organized for the purpose of assuming and spreading among the members all or a portion of their risk exposure. These insurers are exempt from most state insurance laws, other than those of the domiciliary state.

As of December 31, 1992, 45 risk retention groups had notified the Department of their intention to do business in New York under the provisions of the federal legislation. (An additional 14 risk retention groups filed notices of intent that were subsequently withdrawn. Six other risk retention groups are in liquidation or receivership in other states.)

In calendar year 1991, 46 risk retention groups filing financial statements with this Department reported total direct premiums written of $320.6 million and total net premiums written of $154.4 million. These risk retention groups reported direct premiums written of $33.4 million in New York State during this same period.

10. Examinations of Insurers Conducted in 1992

Table 28
EXAMINATIONS CONDUCTED BY THE PROPERTY COMPANIES BUREAU
1992

		Regularly Scheduled Financial Examinations		Other Financial Examinations		
		Initiated				
	Total	In 1992	Prior to 1992	Special	On organization	Increase in capital and other
Total	121	81	37	1	2	--
Fire and marine, casualty and surety, including accident and health companies	83	54	26	1	2	--
Hospital, medical and dental plans	15	11	4	--	--	--
Other insurers and related organizations*	19	13	6	--	--	--
Title and mortgage companies	4	3	1	--	--	--

*Includes Underwriting Members of the New York Insurance Exchange, Inc.

11. Article 43 And Article 44 Corporations*

a. Subscriber Rate Changes

The Property Companies Bureau received 12 premium rate increase applications from Article 43 corporations (including two HMOs) for their community-rated contracts and riders with requested effective dates in 1992. The rates approved were lower than requested on eight of the applications. The rates requested on four of the applications were approved as submitted.

In addition, the Insurance Department received 25 applications for subscriber rate increases from Article 44 HMOs. The approved rates on one of the applications were lower than requested and one application was denied in full. The balance were approved as submitted.

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*Article 43 of the New York Insurance Law governs various non-profit health insurers and Article 44 of the Public Health Law governs health maintenance organizations (HMOs).

Table 29
SUBSCRIBER RATE CHANGES
Article 43 and Article 44 Corporations
1992

	Average Percent Requested	Average Percent Approved	Effective Date
I. Insurance Law Article 43 Corporations:			
Blue Cross/Blue Shield of Central New York, Inc.	24.30%	9.60%	1/1/92
Blue Cross of the Rochester Area, Inc.	15.40	13.70	1/1/92
Blue Shield of the Rochester Area, Inc.	11.20	9.70	1/1/92
Blue Cross of the Rochester Area and Blue Shield of the Rochester Area Jointly Underwritten Contracts	20.50	19.00	1/1/92
Blue Cross of Western New York, Inc.	24.80	21.80	1/1/92
WholeHealth Insurance Network			
Blue Shield of Northeastern New York			
- Region I	14.60	14.60	1/1/92
- Region II	21.50	21.50	1/1/92
Blue Shield of Western New York	13.40	13.40	1/1/92
WholeHealth Insurance Network			
Blue Shield of Northeastern New York			
- Region I	26.70	27.40	10/1/92
- Region II	29.40	27.30	10/1/92
Blue Shield of Western New York	18.90	18.60	10/1/92
Blue Cross/Blue Shield of Utica-Watertown	21.00	17.70	1/1/92
Capital Area Community Health Plan (an HMO)			
Basic and riders	11.50	11.50	1/1/92
Medicare	5.30	5.30	1/1/92
Empire Blue Cross/Blue Shield			
Albany Division	21.30	10.50	4/1/92
Mid-Hudson Division	11.70	5.40	4/1/92
New York City Division	29.20	14.60	4/1/92
Health Care Plan (an HMO)	10.98	10.98	1/1/92
Health Insurance Plan of Greater New York	11.10	11.10	7/1/92

	Average Percent Requested	Average Percent Approved	Effective Date
II. Public Health Law Article 44 Corporations:			
AEtna Health Plans of New York (formerly Healthways)	3.90%	3.90%	1/1/92
*Blue Choice (Blue Cross of the Rochester Area)	13.70	13.70	1/1/92
Capital District Physicians Health Plan	11.20	11.20	1/1/92
ChoiceCare Long Island	11.37	11.37	1/1/92
CIGNA Health Plan of New York (formerly Total Health)	23.10	23.10	7/1/92
*Community Blue (Blue Cross of Western New York)	17.20	17.20	1/1/92
Empire Blue Cross/Blue Shield Healthnet	9.30	9.30	4/1/92
*Group Health (Blue Cross of the Rochester Area)	13.90	13.10	1/1/92
*HIP/HMO (Health Insurance Plan of Greater New York) - Non-Medicare	9.80	9.80	7/1/92
*HealthShield (Capital Area Community Health Plan)			
Region I - Non-Medicare	10.90	10.90	1/1/92
Region II - Non-Medicare	11.10	11.10	1/1/92
Medicare	4.90	4.90	1/1/92
Independent Health Association			
Western New York - Buffalo	7.90	7.90	1/1/92
Hudson Valley Division - North	11.00	11.00	1/1/92
Hudson Valley Division - South	(1.50)	(1.50)	1/1/92
Kaiser Foundation Health Plan of New York	10.07	10.07	1/1/92
MetLife Healthcare Network of New York	7.30	7.30	1/1/92
Mid-Hudson Health Plan	13.10	13.10	1/1/92

	Average Percent Requested	Average Percent Approved	Effective Date
Mohawk Valley Physician's Health Plan			
East Service Area (Excluding Delaware, Otsego and Ulster counties)	15.70%	15.70%	1/1/92
East Service Area (Delaware and Otsego counties)	28.70	28.70	1/1/92
East Service Area (Ulster County)	(3.10)	(3.10)	1/1/92
Central Service Area	19.00	19.00	1/1/92
Mid-Hudson Service Area	19.80	19.80	1/1/92
North Service Area	16.70	16.70	1/1/92
Oxford Health Plans (NY), Inc.	9.90	9.90	1/1/92
Patients' Choice, Inc.	8.63	8.63	1/1/92
Physicians Health Service of New York	13.70	13.70	1/1/92
Prudential Health Care Plan of New York (PruCare)	0.60	0.60	1/1/92
Rochester Area HMO	11.93	11.93	1/1/92
Sanus Health Plan of Greater New York	17.90	17.90	1/1/92
Travelers Health Network of New York, Inc.			
New York City and Rockland County	14.60	14.60	4/1/92
Nassau, Suffolk and Westchester counties	14.80	14.80	4/1/92
Syracuse Division	13.80	13.80	4/1/92
U.S. HealthCare	10.70	- 0 -	1/1/92
U.S. HealthCare For Subscribers Renewing			
04/1/92 - 06/30/92	7.80	7.80	4/1/92
07/1/92 - 09/30/92	7.40	7.40	
10/1/92 - 12/31/92	7.90	7.90	
Wellcare of New York	12.90	12.90	1/1/92

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*Indicates the HMO is a line of business of the corporation shown in parenthesis

b. Growth of Article 43 and Article 44 Corporations

The following tables show aggregate figures on assets, liabilities, premium income and membership for years 1987-1991:

TABLE 30
ARTICLE 43 HEALTH SERVICE CORPORATIONS*
Selected Data, New York State
1987-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1987
Admitted Assets	$4,093.9	$3,868.7	$3,359.3	$3,197.5	$2,910.1
Liabilities	3,689.7	3,341.2	2,911.1	2,785.4	2,454.7
Surplus Funds	$404.2	$527.5	$448.2	$412.1	$455.4
Net Premium Income					
Hospital	$7,578.1	$7,118.3	$6,350.3	$5,705.3	$4,707.6
Medical/Dental	3,541.8	3,148.0	2,703.8	2,302.2	2,054.5
No. of Contract Holders					
Hospital	6.7	7.0	7.1	7.1	6.8
Medical/Dental	4.6	4.4	4.4	4.6	4.3

*Insurance Law Article 43 Health Service Corporations are permitted by the provisions of Section 4301(e) of the Insurance Law to provide coverage for hospital service and medical and dental care. They are also granted certain additional powers to permit the development of comprehensive health care plans.

Source: New York State Insurance Department

TABLE 31
ARTICLE 43 MEDICAL & DENTAL EXPENSE INDEMNITY CORPORATIONS
Selected Data, New York State
1987-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1987
Admitted Assets	$53.8	$45.4	$44.2	$44.3	$44.4
Liabilities	35.4	30.5	29.6	38.6	32.1
Surplus Funds	$18.4	$14.9	$14.6	$5.7	$12.3
Net Premium Income	$152.9	$146.3	$139.3	$115.8	$112.5
Number of Contract Holders	0.4	0.4	0.5	0.4	0.4

Source: New York State Insurance Department

TABLE 32
HEALTH MAINTENANCE ORGANIZATIONS THAT ARE A LINE OF BUSINESS OF AN ARTICLE 43 HEALTH SERVICE CORPORATION*
Selected Data, New York State
1987-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1987
Net Premium Income*	$1,722.6	$1,412.2	$1,167.0	$975.5	$713.0
Participants	1.4	1.4	1.4	1.4	1.3

*Figures shown in this Table are included in the corresponding figures shown in Table 30.

Source: New York State Insurance Department

TABLE 33
HEALTH MAINTENANCE ORGANIZATIONS THAT ARE NOT A LINE OF BUSINESS
Selected Data, New York State
1987-1991

(dollar amounts in millions)

	1991	1990	1989	1988	1987
Admitted Assets	$672.4	$549.6	$399.0	$292.1	$227.7
Liabilities	478.9	413.5	310.5	227.8	164.5
Surplus Funds	$193.5	$136.1	$88.5	$64.3	$63.2
Net Premium Income	$1,787.4	$1,344.6	$1,012.7	687.0	$492.3
Participants	1.5	1.3	1.2	1.0	0.8

Source: New York State Insurance Department

12. Hedging Regulation 142

On April 22, 1992, the Superintendent promulgated Regulation 142, entitled "Rules Governing Bona Fide Hedging and Income Enhancement Transactions of Authorized Property/Casualty Insurers." The Regulation, which took effect on June 1, 1992, allows property/casualty insurers to use these transactions to protect the value of assets from fluctuations in market value and to protect foreign investments and liabilities from fluctuations in value due to changing foreign currency rates. The Regulation sets forth the rules and procedures insurers must adhere to when engaging in the hedging and income enhancement transactions permitted by Section 1403(d)(7) of the Insurance Law. It requires these insurers to submit a written plan setting forth their investment objectives and financial and operational capability to engage in such transactions. At the same time, the First Amendment to Regulation 72, which deals with covered call options, was promulgated to delete property/casualty insurers from its provisions, as such insurers must now comply with the provisions of Regulation 142, which includes covered call transactions.

13. Investment Law Amendment

On July 17, 1992, the Governor signed a bill, which became effective January 1, 1993, amending various investment provisions contained in the New York Insurance Law applicable to property/casualty insurers. The main purpose of the Bill is to simplify the investment rules applicable to non-life insurers and to afford property/casualty insurers expanded opportunities to invest in subsidiaries.

14. NAIC Risk-Based Capital Working Group

Vincent Laurenzano, Chief of the Property Companies Bureau, continues to chair the NAIC Property/Casualty Risk-Based Capital Working Group. The goals of this ambitious and far reaching project are to:

- relate capital and surplus requirements of an insurer to the risks inherent in its particular operations;
- establish a universally recognized capital standard; and
- provide regulators with the authority to enforce compliance with more appropriate capital requirements.

This project is expected to continue throughout 1993.

C. HEALTH AND LIFE POLICY BUREAU

1. Review of Life and Accident and Health Policy Forms

The Health and Life Policy Bureau processed 14,323 life, annuity and accident and health policy forms in 1992, including 124 fraternal benefit society certificate forms, constitutions, by-laws, articles of incorporation and amendments thereto.

Table 34
LIFE AND ACCIDENT & HEALTH POLICY FORMS PROCESSED
1992

Total	14,323
Individual Life	1,595
Individual Annuity	744
Individual Accident and Health	1,226
Group Life	419
Group Accident and Health	4,885
Combination Group Life and Health	937
Blanket	892
Article 43 Organizations	748
HMO	624
Credit Life	264
Credit Accident and Health	94
Credit Unemployment	7
Variable Life and Annuity	469
Fraternals	124
Group Annuity	1,286
Funding Agreements	8
Pre-Paid Legal	1

Of the 14,323 total, 7,284 forms were approved for use both in and out of state; 2,168 forms were either disapproved or withdrawn; 4,411 forms were filed for use in states other than New York; and 460 forms or memoranda explaining variable contract language were filed for reference purposes.

2. Review of Accident and Health Rate Filings

The 982 rate filings processed by the Bureau consisted of 360 individual accident and health, and 622 group or blanket accident and health filings.

3. Pre-filings, Inquiries and Complaints

In conjunction with the policy form and premium rate review process, the Bureau processes pre-filings and responds to inquiries and complaints. The Bureau processed 114 pre-filings of policy form submissions in 1992, and provided written answers to 760 inquiries concerning policy forms or related issues and 108 inquiries relating to premium rates.

4. Community Rating/Open Enrollment

a. Background

On July 17, 1992 the Governor signed into law Chapter 501 of the Laws of 1992. This legislation requires community rating for individual and small group health insurance and the coverage must be furnished on an open-enrollment basis. Insurers are permitted only a pre-existing condition limitation for protection from adverse selection.

The legislation was designed to address an increasing lack of availability of health insurance at affordable premium rates for individuals and small groups. For many years, the Blue Cross and Blue Shield plans in New York have offered health insurance coverage to individuals and small groups on an open-enrollment basis. Many commercial insurers do not participate in the individual and small group markets. Those commercial insurers choosing to write such business in New York did not do so on an open-enrollment basis. Rather, they engaged in underwriting practices that resulted in the rejection of applicants posing poor health risks. Small employer groups were often rejected if they were engaged in a business or industry deemed unacceptable by the commercial carriers.

The selective underwriting practices of the commercial insurers enabled them to form risk pools of relatively healthy lives and, as such, offer insurance coverage at a reduced cost when compared with open enrollment plans. Those individuals and small groups that could meet the underwriting criteria of the commercial insurers were enticed away from the open enrollment plans offered by Blue Cross and Blue Shield. Those higher risk individuals and small groups that could not meet the screening criteria of the commercials had little choice other than the open enrollment coverage of the not-for-profit insurers. As a result, the community pools of the Blue Cross and Blue Shield plans have become more costly and contain a disproportionate share of unhealthy risks.

b. Effective Dates

The community rating and open enrollment requirements of Chapter 501 apply to new individual and small group policies delivered in New York on or after April 1, 1993. The law also generally applies to in-force coverage as of April 1, 1993. However, for existing policies and contracts delivered in New York and existing coverage effectuated in New York on or after April 1, 1992 but before Chapter 501 was signed into law by the Governor (July 17, 1992), the legislation applies as of the date of their next renewal rating period.

In addition, Insurance Department Regulation 145 (11 NYCRR 360) has addressed the applicability of the open enrollment requirements of Chapter 501 as they relate to certain previously issued lines of business. For example, the Regulation provides that the open enrollment requirements of the law do not apply to guaranteed renewable and noncancelable policies issued prior to February 1, 1993, unless the insurer issued new policies on or after that date. The Regulation also provides that for community-rated policies sold only on an open-enrollment basis, an insurer may continue to renew the policies without accepting any new applicants. For existing policies not sold after July 17, 1992, an insurer must community rate such policies but need not accept any new applicants. However, the Regulation allows an insurer to request an exemption from the community rating requirement upon showing that the policy has not been sold for a significant period of time and either covers a very small number of individuals or has been subsidized by the insurer for an extended period of time. With respect to group coverage not sold after July 17, 1992, policies or certificates may be issued on an open-enrollment basis to new entrants to groups, and such issuance does not require that the insurer accept any new group applicants for such coverage.

c. Regulation 145

On December 22, 1992, the Department promulgated Regulation 145 as an emergency measure pursuant to Section 202(6) of the State Administrative Procedure Act (SAPA) in order to clarify various provisions of Chapter 501 of the Laws of 1992 and to assist insurers and health maintenance organizations in complying with the new requirements for the pricing and sale of health insurance for individuals and small groups in New York State. Regulation 145 addresses a number of the major requirements of Chapter 501 by defining certain terms such as open enrollment and community rated; prohibiting specific underwriting practices and eligibility rules; establishing specific criteria for the imposition of pre-existing condition waiting periods, including the crediting of time covered under previous health insurance plans or policies or employer-provided health benefit arrangements; prescribing rules to govern the enrollment of individuals and small groups through association groups; and setting standards for the filing and approval of rates by commercial insurers intending to change to a community rating methodology. The Regulation also establishes rules for the implementation of related areas, such as the continuation of health insurance benefits; a prohibition on providing administrative services or stop loss, catastrophic or reinsurance coverages to self-insured arrangements; and the disclosure rules for replacement of Medicare supplement insurance.

As defined in Regulation 145, open enrollment means that any individual and any small group applying for individual or small group health insurance coverage must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer or health maintenance organization to individuals or small groups in New York State. In addition, once accepted for coverage, an individual or small group cannot be terminated by the insurer or health maintenance organization due to poor claims experience. The Regulation defines community rated as a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. Refunds, rebates, credits or dividends based on such factors are also prohibited.

Under the open enrollment requirements of Regulation 145, insurers are permitted, but not required, to offer small group health insurance policies and individual health insurance policies, while health maintenance organizations are required to offer such coverage. Health insurance policies offered to individuals or small groups on or after April 1, 1993, must be open enrolled and community rated. Regulation 145 also specifies the circumstances under which policies that remain in force may not be subject to the requirements for community rating or open enrollment.

The Regulation identifies specific underwriting practices that are prohibited by open enrollment requirements, including asking questions as to the health, occupation and avocational interests of the applicant. The use of any such information, regardless of the source, is also prohibited. "Actively at work" requirements and overinsurance standards predicated merely upon eligibility for other coverage are prohibited. Regulation 145 prohibits insurers and health maintenance organizations from using eligibility rules that restrict the availability of individual and small group health insurance coverages except as specifically provided.

Rules based upon conditions pertaining to employment, including a minimum number of working hours per week not to exceed 20, are permitted. While participation requirements are permitted, in establishing such requirements insurers must include as eligible employees or members of the group those individuals covered under all alternative HMO options offered by the employer. In addition, insurers and health maintenance organizations may establish rules to control the ability of employees to transfer among the various health plan options offered by the employer.

Regulation 145 prescribes rules governing policy provisions restricting or limiting coverage based upon a pre-existing condition limitation. Such provisions may not restrict or limit coverage beyond 12 months following the effective date of coverage and may apply to only those conditions manifesting symptoms that would cause an ordinary prudent person to seek treatment within six months immediately preceding the effective date of coverage. It also provides that an individual who transfers coverage must be credited with time covered under the prior coverage to the extent such coverage was substantially similar to the new coverage and continuous up to a date 60 days prior to the effective date of the new coverage. Special rules are stated for HMO and Medicare supplement coverage.

The Regulation establishes standards relating to various aspects of group health insurance policies issued to association groups. Insurers and health maintenance organizations may not write only association group policies, but may opt to write only small employer groups (and for health maintenance organizations, individual policies as well) and not association group business. The Regulation permits an association group qualifying under Section 4235 (c)(1)(B) or (K) of the Insurance law to obtain its own community rate if it covers at least 10,000 persons in New York State, membership includes individuals from diverse and unrelated industries or occupations, and the policy issued to the association group with its own community rate is also offered on an open-enrollment basis to any other association or small group. Regulation 145 also clarifies that Chapter 501 applies to an association group as long as one participating group member has 50 or fewer employees or members. However, the Regulation permits a split of an association into an experience-rated policy covering all group members with more than 50 employees or members and a community-rated policy for group members with 50 or fewer employees or members.

Regulation 145 makes it clear that the community rating and open enrollment requirements apply to certain New York residents covered under a group policy delivered to a group trust outside New York State without regard to the "deemed to be delivered" requirements of Section 3201 of the Insurance Law. Only a pooled community rate methodology is permitted and such coverage must be written on a policy available in New York State for other small groups on an open enrollment and pooled community rate basis. If compliance is not possible, then such out-of-state coverage may not be offered to New Yorkers.

Regulation 145 establishes rules governing community rates, including the filing and approval of rates by commercial insurers intending to change to a community-rating methodology. It requires that the experience of an insurer's or health maintenance organization's community-rated policies be pooled when such policies provide substantially similar benefits. It prohibits insurers and health maintenance organizations from developing separate community rates where the only benefit variations in policies are in deductibles, coinsurance amounts, number of days or visits covered, or the addition or deletion of benefits that do not substantially impact premiums. The Regulation allows insurers and health maintenance organizations to establish separate experience pools for individuals and small groups, but encourages those that currently utilize one pool for developing community rates for both individuals and groups to continue this practice. It also permits insurers and health maintenance organizations to continue to use existing family rating structures for family coverage and to retain geographic rating areas in use prior to July 17, 1992, if those areas are determined to be acceptable to the Superintendent.

The Regulation requires the elimination of such factors as age, sex, occupation, income, and substandard and preferred risk factors in rating classifications. It also requires that policies issued with individual restrictions or exclusions of coverage for specified conditions eliminate such restrictions or exclusions by March 31, 1993.

d. Regulation 146

Regulation 146 (11 NYCRR 361) was promulgated on December 22, 1992 as an emergency measure pursuant to Section 202(6) of the State Administrative Procedure Act. Regulation 146 establishes a demographic and specified medical condition pooling mechanism as required by Section 3233 in order to protect insurers and health maintenance organizations providing health coverage to individuals and small groups from undue claim fluctuations as a result of the open enrollment requirements of Chapter 501 of the Laws of 1992.

Regulation 146 is designed to encourage insurers to remain in or to enter the individual or small group health insurance market where premiums do not unduly fluctuate as a result of substantive cost variations attributable to significant differences in demographic characteristics of insured persons such as age, sex and health conditions.

The stabilization pooling mechanism includes two components. The first component establishes two demographic pools in each of seven geographic areas in the State as follows: Albany, Buffalo, Mid-Hudson, New York/Metropolitan, Rochester, Syracuse and Utica/Watertown. In each area, there will be one demographic pool for individual and small group hospital and medical coverage and another demographic pool for Medicare supplement coverage. An age/sex relative morbidity table is used to measure the relative risk or the typical plan cost for each insurer in each pool. If an insurer has a relative risk factor greater than the average for all participating insurers in a specific demographic pool, then such insurer would receive money from that pool. Insurers with a relative risk factor below the average for all participating insurers in a specific pool would contribute money to that pool.

Insurers that expect to make contributions to a specific pool are permitted to include such projected contributions in their premium rates as anticipated claim expenses. Those insurers that expect to receive money from a specific pool must treat such projected receipt as a claim offset which will reduce such insurers' premium rates below the level that otherwise would have been charged by the insurers.

The second component of the stabilization pooling mechanism establishes a third pool in each of the seven geographic areas reflecting the cost of treating certain catastrophic medical conditions specified in the Regulation. Each insurer receives from the pool a pre-determined amount, varying by condition for each insured diagnosed with that condition. This pooling of certain specified catastrophic conditions will minimize the adverse financial impact on those insurers that incur a disproportionate number of such claims because of the open enrollment requirements of Chapter 501.

The Regulation provides that any excess in a demographic pool will be carried over to pay pool participants in the following year. If a pooling fund is not sufficient to pay all participating insurers in that pool, the amount to be paid to each insurer will be reduced proportionately on the basis of available funds in that specific demographic pool. The pool for specified catastrophic medical conditions treats insufficient and excess funding in the same manner.

The stabilization pooling mechanism is based on reasonably available data that account for a significant portion of the premium cost difference among insurers due to demographics and high cost medical conditions, but it is recognized that these factors are not expected to account for all of the differences in premium cost among insurers. A more precise adjustment process would require a significant increase in administrative efforts, yielding marginal improvement in results. Premium cost variations among insurers based on operational efficiency and ability to manage health care costs are not intended to be neutralized, and are indeed encouraged.

Administration of these pools is expected to be contracted out on a competitive bid basis. Finally, Section 361.6 of Regulation 146 provides that the Superintendent shall prepare a report on or before July 1, 1994 analyzing the effectiveness of the stabilization pooling mechanism and the Superintendent may make appropriate changes in the demographic and specified medical conditions pools established pursuant to Chapter 501 of the Laws of 1992.

5. Hospital Payment Rate Surcharge

The Department issued Circular Letter No. 10 (1992) on June 16, 1992, addressed to all insurers licensed to write accident and health insurance other than those corporations licensed under Article 43 of the Insurance Law, setting forth guidelines for determining the amount of reimbursement to hospitals based upon the requirements of Chapter 55 of the Laws of 1992, which established a Supplementary Payment Rate Conversion Factor Statewide Pool. Circular Letter No. 10 was issued in conjunction with the Department of Health's June 16, 1992 release of instructional guidelines to assist hospital administrators and comptrollers in complying with the payment and reporting requirements imposed on hospitals by the law.

The new 11% Supplementary Payment Rate Conversion Factor applies to commercial insurance policies providing inpatient hospital benefits on an expense incurred basis, but does not apply to:

- payments made under a stop loss policy which is usually designed to indemnify an employer for losses incurred under a self-funded plan in excess of a specified loss limit;

- arrangements by which the commercial insurer acts as a third-party administrator under an administrative services agreement; and

- indemnity policies that provide a fixed payment for each day of confinement without regard to the actual expenses incurred during the hospital stay.

However, such law does apply to employer "minimum premium" group health insurance plans.

Circular Letter No. 10 (1992) advised that until insurers implement procedures to assist hospitals in properly identifying those patients covered under an insurance plan subject to the Supplementary Payment Rate Conversion Factor, hospitals were instructed by the Department of Health to include the 11% Supplementary Payment Rate Conversion Factor in all claims submitted to commercial insurers leaving it to the insurers to adjust those claims exempt from the 11% conversion factor.

Circular Letter No. 10 identified the following four specific Department of Health instructional guidelines that would directly impact commercial insurers:

1. The Supplementary Payment Rate Conversion Factor applies regardless of whether the insurer pays the hospital directly, allows for assignment of benefits by the insured, or uses a two-party check system of payment;

2. The Supplementary Payment Rate Conversion Factor does not apply when the commercial insurer is determined to be a secondary payor;

3. For inpatient services rendered at facilities where the hospital is not reimbursed on a diagnosis-related group (DRG) basis, such inpatient services shall be paid at the per diem payment amount increased by the 13% Payment Rate Conversion Factor plus the new 11% Supplementary Payment Rate Conversion Factor; and,

4. The statutory 2% discount available to commercial carriers for payment in full made within ten calendar days from receipt from the hospital of a full and final bill is applied to the full 24% payment factor (13% Payment Rate Conversion Factor and the 11% Supplementary Payment Rate Conversion Factor).

6. Stop Loss Insurance/ERISA Pre-emption

As part of the Travelers Insurance Company lawsuit in United States District Court for the Southern District of New York challenging the applicability of the hospital reimbursement surcharges as set forth in Section 2807 c-1(b) of the Public Health Law to certain payors because such state law is pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), the Travelers also alleged that the Insurance Department's Actuarial Information Letter No. 5 was pre-empted by ERISA. This Actuarial Information Letter sets forth certain internal guidelines used by the Bureau for the approval of policy forms that provide stop loss accident and health insurance coverages. At issue is whether or not a self-insured employer purchasing a stop loss policy to cover catastrophic health claims under the self-insured portion of the employer's welfare benefit plan should be treated as an insured plan thus "saved" from pre-emption under ERISA permitting state insurance laws and regulatory requirements to apply to such arrangement. Under stop loss arrangements, an insurer will reimburse the employer if health claims exceed a specified amount, either on a per claim basis or on an aggregate basis within a specified period of time. Usually, the insurer has no direct obligation to pay health benefits to the employee. Rather the insurer is obligated to pay claims on behalf of the employer pursuant to an administrative services only (ASO) contract and reimburse the employer for excess claim liability under the stop loss contract. It has been the Department's view that stop loss contracts that reimburse an employer for medical and hospital expenses above certain amounts are subject to some of the same requirements applicable to other accident and health contracts providing hospital and medical coverage.

The more significant rules of the Actuarial Information Letter are:

1. the insurer must undertake to insure that statutory mandated benefits are covered under the employer's plan;
2. the insurer will provide a statutory conversion right;
3. the insurer must maintain full liability for all runoff claims;
4. the insurer must establish reserves for such liability; and
5. multiple employer trust and association arrangements are not eligible for stop loss arrangements.

A federal court may find in favor of pre-emption because some or all of these rules affect or impact the self-insured portion of the employer's welfare benefit plan. While the ERISA savings clause exempts from pre-emption any state law that regulates insurance the ERISA "deemer clause" limits the scope of the "savings clause" to insured welfare benefit plans. Thus, an uninsured welfare benefit plan cannot be subject to state insurance laws. The critical issue is whether or not a self-funded welfare benefit plan purchasing stop loss coverage becomes an insured welfare benefit plan.

7. Multiple Employer Welfare Arrangements

Multiple Employer Welfare Arrangements (MEWAs) provide health insurance benefits to the employees of two or more employers that may include multiple employer trust (MET) groups and employer association type groups. Chapter 501 of the Laws of 1992 was drafted so that the small group underwriting and rating reforms apply to all insured MEWAs, including out-of-state MEWAs, to the extent that such MEWAs (multiple employer trust and association groups) include one or more New York employers with 50 or fewer employees.

The open enrollment and community rating requirements in Chapter 501 should serve to deter entrepreneurs, including third-party administrators (TPAs) and insurance brokers, interested in promoting administrative and marketing services, from using the multiple employer trust and association group format to fragment and disrupt the small group health insurance market. It is widely recognized that the multiple employer trust and association group format has permitted MEWA promoters and their insurers to adopt rating and underwriting practices designed to exclude those individuals and small groups that are most in need of insurance protection and to periodically create new trusts or blocks of business for better risks, leaving the older existing blocks to suffer assessment spirals in which only older and unhealthy lives remain resulting in large claim losses and exorbitant premium rates.

To ensure that the small group underwriting and rating reforms in Chapter 501 apply to all insured MEWAs providing coverage in this State, the Department is prepared to propose legislation amending the mail order law to remove any doubt that such reforms apply to coverage effectuated in this State under out-of-state group policies issued by unlicensed insurers.

For partially insured MEWAs, the Bureau has advised a number of insurers and administrators that the self-insured retention associated with minimum premium and stop loss coverage purchased by or on behalf of a MEWA constitutes doing an insurance business which must be authorized by a license or be specifically exempted from such requirement. The Department is concerned not only with the MEWAs' financial well-being with respect to such self-insured retention but with the prospect that MEWA promoters will use minimum premium and stop loss coverage to circumvent the community rating requirement for small employers. This would undermine the community pools of those insurers active in the small group market and participating in the stabilization mechanism required by Section 3233, and would otherwise thwart the salutary purposes of Chapter 501.

With respect to self-funded MEWAs, the U.S. General Accounting Office (GAO) has issued a report (GAO/HRD-92-40) stating that fraudulent and mismanaged MEWAs have left hundreds of thousands of workers and their dependents without insurance and with unpaid claims measured in the hundreds of millions of dollars on a nationwide basis. To date, except as noted below, New York residents have been spared much of the hardship and pain inflicted by self-funded MEWAs. The Department was successful in closing and liquidating one such self-funded MEWA (Empire Benefit Plans, Inc.) before claims exceeded assets because the program was detected early.

Without early detection, there is no assurance that a future occurrence will have such a favorable outcome. The Department has proposed legislation that requires all MEWAs not fully insured to be licensed as insurers. Licensing should serve to ensure that such self-funded MEWAs are competently managed and adequately funded and should permit the early detection of problems by the Department.

However, licensing of such arrangements will not protect New York residents from promoters who exploit the exceptions in ERISA for MEWAs that are subject to collectively bargained agreements, and employee leasing firms. Although New York, unlike other states, has been fortunate in escaping problems involving self-funded plans sponsored by employee leasing firms, the Department has received hundreds of complaints involving a dozen or more union sponsored associate membership programs that claim to be exempt from state regulation as collectively bargained arrangements. Under such programs unions market their health plans to unrelated employers and employees and closely resemble MEWAs in structure and operation.

The Department has serious reservations as to whether such union sponsored associate membership programs qualify as collectively bargained programs that are thus exempt from state regulation. Complaints concerning these programs have been referred to the U.S. Department of Labor because, under ERISA, the Secretary of Labor must make a finding whether such plans or arrangements are established or maintained under or pursuant to one or more collective bargaining agreements. Even though the U.S. Department of Labor recognizes that the collective bargaining exception can be exploited by MEWA promoters, so far that Department has not found any such program to be ineligible for the exemption from state regulation.

Without definitive guidance from the federal government concerning the qualified status of such union association member programs, New York and other states have been reluctant to act. As a result, a number of questionable programs and promoters have preyed upon unsuspecting workers and vulnerable employers in an unregulated environment. While collectively bargained programs are exempt from the small group rating and underwriting reforms in Chapter 501, the exploitation of the collective bargaining exception may undermine New York's small group reform efforts.

8. Medicare Supplement Insurance

a. Revised Minimum Standards

On March 12, 1992, the Superintendent promulgated the Seventeenth Amendment to Department Regulation 62 to be effective on April 1, 1992 and applicable to all policies and certificates of Medicare supplement insurance delivered or issued for delivery in this State on or after May 1, 1992. The Seventeenth Amendment sets forth revised minimum standards for the form, content and sale of Medicare supplement insurance and is intended to provide for standardization of coverage and simplification of the contractual terms of Medicare supplement policies in order to facilitate consumer understanding and comparison of such policies.

The Seventeenth Amendment adopts the ten standardized Medicare supplement plans labelled "A" through "J" developed by the National Association of Insurance Commissioners (NAIC) in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA). The NAIC Medicare Supplement Insurance Model Regulation, which OBRA establishes as a minimum regulatory standard for the states, requires all insurers offering Medicare supplement coverage to make available a "basic core" benefit package (Plan A) covering the patient's coinsurance costs for hospital stays; costs incurred for hospitalization expenses for an additional 365 days (lifetime) upon exhaustion of Medicare benefits; charges for the first three pints of blood; and 20% co-payment responsibility of the patient under Medicare Part B for medical services. The Seventeenth Amendment requires insurers to also make Plan B available in addition to Plan A. Benefit Plan B includes full coverage of the Medicare Part A inpatient hospital deductible amount in addition to the core benefits required to be included in all benefit plans (A through J). Benefit Plan B comports with New York's preceding minimum standards for policies of Medicare supplement insurance. By requiring insurers to offer both Benefit Plans A and B, the Insurance Department does not weaken existing minimum standards and ensures the availability of policies that cover the inpatient hospital deductible amount at a reasonable cost.

In addition, the Seventeenth Amendment provides rules for full disclosure in the sale of accident and health insurance coverage to persons eligible for Medicare; prohibits the sale of Medicare supplement insurance coverage to an individual currently covered under another Medicare supplement policy; requires additional disclosure and added agents' responsibilities if the consumer intends to replace existing Medicare supplement coverage; limits agents' compensation; requires policies to be guaranteed renewable; requires the waiver of any waiting period in a Medicare supplement policy for pre-existing conditions to the extent such time period has expired under an existing Medicare supplement policy or certificate that is being replaced by a new policy or certificate; provides consumers with the right to suspend coverage and payment of premiums for a maximum period of 24 months when the consumer is eligible for Medicaid; provides a conversion privilege in group policies to an individual policy; provides a six-month open-enrollment period to Medicare beneficiaries age 65 or older commencing in the month in which the consumer enrolls for Medicare Part B; and provides additional actuarial standards to effectuate more comprehensive monitoring of insurers' loss experience under such policies with new procedures for premium refunds to consumers in the event that insurers' loss experience has not met the applicable minimum loss ratio standard for Medicare supplement insurance.

b. Consumer Information

Due to the significant number of changes required by the Omnibus Budget Reconciliation Act of 1990, the Seventeenth Amendment to Regulation 62, and Chapter 501 of the Laws of 1992 which contains provisions becoming effective on January 1, 1993 and April 1, 1993, the Department delayed revision of its consumer guide, Medicare Supplement Insurance in New York State. The guide will be substantially revised for publication in 1993 after implementation of the aforementioned statutory and regulatory requirements. The delay will allow the Department to make the guide more complete and will provide consumers with the information they desire, such as the most up-to-date premium rates which as of April 1, 1993 will be community rates.

In the interim, the Department has made available to consumers and other interested parties the 1993 edition of the Guide To Health Insurance for People with Medicare (a publication developed jointly by the NAIC and the Health Care Financing Administration (HCFA)), accompanied by a list of insurance carriers with standardized Medicare supplement insurance benefit plans approved for sale to residents of New York State. The Guide includes information on what Medicare pays and does not pay; types of private health insurance; tips on shopping for private health insurance; and the ten standardized Medicare supplement benefit plans. The accompanying list sets forth the name, address and telephone number of each Medicare supplement insurer, as well as a breakdown of the standardized benefit plans offered by each insurer. Such list is updated whenever the Department approves additional policies and/or certificates.

c. Oversight on State Regulatory Effectiveness

By letter dated July 1, 1992, the Health Care Financing Administration advised the Superintendent that the Secretary of Health and Human Services had approved New York's Medicare Supplement Insurance Regulatory Program. The Secretary found that New York's Program provides for application and enforcement of standards and requirements equal to or more stringent than the federal standards for Medicare supplement insurance mandated under Section 1882 of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1990.

The Robert Wood Johnson Foundation has initiated a project designed to evaluate the implementation of the Omnibus Budget Reconciliation Act of 1990 as it pertains to Medicare supplement insurance. Originally designed as a three-year project, eight states including New York were selected for site visits regarding state implementation of the federal requirements. New York site visits took place on January 7, 1992 and January 26, 1993. The Department has been advised that the project will likely be extended to a five-year study period and it is expected that additional site visits and survey reports will be required in order to track the experience and effectiveness of state implementation of the federal standards.

d. Health Insurance Counseling Efforts

In the Omnibus Budget Reconciliation Act of 1990, Congress authorized the appropriation of monetary grants to states with approved Medicare supplement insurance regulatory programs to provide information, counseling and assistance relating to the procurement of adequate and appropriate health insurance coverage for Medicare beneficiaries. In 1992 New York was awarded a grant and the Governor designated the State Office for the Aging (SOFA) to administer the Counseling Program to be established with the grant monies in cooperation with other State agencies. On July 7, 1992 the Insurance Department provided the Office for the Aging with a Letter of Commitment regarding the federal health insurance counseling grant. The Insurance Department has agreed to provide SOFA with up-to-date and timely information concerning changes in law or regulations pertaining to Medicare supplement insurance and long-term care insurance; technical assistance to SOFA staff and interpretations of laws and regulations pertaining to the health insurance for the elderly; and publication of consumer information on Medicare Supplement insurance and long-term care insurance.

Pursuant to such agreement the Bureau has reviewed and will continue to review SOFA-generated information before its dissemination to SOFA's network and to the public. The Bureau also provided staffing to SOFA on November 17, 1992 for a half day call-in session on the SOFA Senior Citizens Hotline on the topic of Medicare supplement insurance. It is anticipated that the Department will participate in future call-in sessions on the topics of Medicare supplement insurance and long-term care insurance.

9. Long-Term Care

a. Coverage Available under the Sixteenth Amendment to Regulation 62

On January 1, 1992 the Sixteenth Amendment to Regulation 62 (11NYCRR 52) became effective. The Sixteenth Amendment established minimum standards for the form, content and sale of long-term care type insurance including specific benefit standards for four defined categories of policies or certificates:

- long-term care insurance
- nursing home and home care insurance
- nursing home insurance only
- home care insurance only.

The Sixteenth Amendment sets forth permissible policy limitations or exclusions; conversion and benefit continuation rights; a prohibition of a prior requirement for confinement in a hospital or nursing facility in order to be eligible for long-term care benefits; a requirement to offer an inflationary protection benefit and a nonforfeiture benefit; minimum loss ratio standards; and standardized disclosure statements that must be provided to consumers.

At the end of 1992 the Health and Life Policy Bureau had approved individual policies of six insurers that met or exceeded the requirements of the Sixteenth Amendment to Regulation 62 for long-term care insurance. Policies of three insurers that met or exceeded the requirements for nursing home and home care insurance, and policies of three insurers that met or exceeded the requirements for nursing home insurance only were also approved. Two insurers had received approval of group long-term care products.

b. Robert Wood Johnson Foundation (Long Term Care Security Demonstration Program) and Department Regulation 144

The Health and Life Policy Bureau continued to work with other State agencies participating in the Robert Wood Johnson Long Term Care Insurance Strategy Workgroup. Other agencies include the Departments of Health, and Social Services, the Division of the Budget and the State Office for the Aging. In early 1992 the Health Care Financing Administration of the U.S. Department of Health and Human Services granted the necessary Medicaid plan amendments to make it possible to implement the public/private partnership. This implementation would allow an individual who purchases a qualifying long-term care insurance policy/certificate from an authorized insurer to receive continued long-term care coverage through Medicaid after policy/certificate benefits have been exhausted without meeting the usual asset spend-down requirements of Medicaid.

Regulation 144 (11 NYCRR Part 39) was promulgated in November 1992 and sets minimum benefit standards for qualifying long-term care insurance policies/certificates under the public/private partnership. Regulation 144 incorporates by reference the minimum standards for long-term care insurance as set forth in the Sixteenth Amendment to Regulation 62 and applies said requirements to qualifying policies/certificates under the public/private partnership project unless there are more stringent requirements set forth in Regulation 144. These more stringent requirements of Regulation 144 are necessary in order to protect the viability of the New York State Medicaid program which is legally bound to waive its asset spend-down requirements once the benefits of a qualifying policy/certificate are exhausted. Coverage sold only under the Sixteenth Amendment to Regulation 62 without the more stringent requirements of Regulation 144 and, therefore, not qualifying under the public/private partnership, does not have the guarantee that Medicaid will waive its usual asset spend-down requirements once policy/certificate coverage is exhausted. Thus, such nonqualifying coverages are not directly linked to the viability of the Medicaid program.

Regulation 144 sets a three-year minimum nursing home benefit and a six-year minimum home care benefit. Inflation protection is mandatory for all issue ages through age 79. There are requirements for respite care, alternate care, elimination periods and added types of home care benefits.

At the end of 1992 it was anticipated that several insurers would make policy/certificate and rate filings to the Bureau to comply with Regulation 144 once the New York State Department of Social Services had completed its work on contractual agreements necessary to implement the public/private partnership with participating insurers.

10. Balance Billing

The Department participated in meetings with the Departments of Law and Health and the State Office for the Aging concerning enforcement of Section 19 of the Public Health Law which limits the amount physicians may charge Medicare beneficiaries. In order for the Department of Law to initiate legal action against the worst offenders of the State's "Balance Billing" Law, that agency sought to obtain information from the Health Care Financing Administration of the U.S. Department of Health and Human Services on the worst offenders of the federal law. However, at year end HCFA had not yet provided the Department of Law with the requested information.

As an additional approach, the Health Care Financing Administration was asked by the Department of Health to include on the Explanation of Medicare Benefits (EOMB) forms given to Medicare beneficiaries, information concerning the limitations placed upon physician charges pursuant to Section 19 of the Public Health Law. HCFA was unwilling to amend the EOMB to include such specific information due to its imminent implementation of standardized computer software to be used nationwide. HCFA was willing to study other alternatives to assist the State, such as dissemination of general information regarding the Balance Billing Law either on the back of the EOMB or as a separate notice to be enclosed with the EOMB. The notice would advise the Medicare beneficiary that the service provided by the physician may also be subject to limitations imposed by state law and that the Department of Health will provide an address and/or telephone number to which questions regarding such state limitations may be directed.

HCFA also advised that it would study the possibility of providing a general notice regarding New York's limitations in the biweekly notice sent to physicians with apparent overcharges based upon the federal limiting charge rules. HCFA also agreed to provide the Department of Health with the names and telephone numbers of contact persons at the Medicare intermediaries to discuss the inclusion of information on the New York law in the bulletins that are sent both physicians and beneficiaries by the intermediaries (approximately two or three times a year). HCFA further agreed to share information with the State Office for the Aging to assist that agency in the preparation of the report required by Public Health Law Section 19.

As of mid-1992, two claims-processing systems were being utilized by the Medicare intermediaries in New York State. Empire Blue Cross/Blue Shield and GHI were using a processing system that was developed by Metropolitan Life Insurance Company and administered by a company in Baltimore, MD. Blue Shield of Western New York was beginning a pilot project with an electronic data system for processing claims. Beginning in July, Blue Shield of Western New York intended to send biweekly reports to physicians whose claims processed during the preceding two weeks contained apparent overcharges based upon the federal limiting charge rules. It was anticipated that by early fall 1992, the EOMBs generated by Blue Shield of Western New York would include information advising beneficiaries on individual claims of their liability when billed charges exceed the limits permitted by federal law. It was hoped that notification to the provider and to the beneficiary that the limiting charge had been exceeded on a particular claim would be given at approximately the same time. Blue Shield advised providers in writing of the new compliance program, including notification that where a provider receives notification of an apparent overcharge, Blue Shield will periodically monitor the provider's billing practices and verify that the provider has made refunds to beneficiaries where overcollection has occurred. It was hoped that the remaining intermediaries would have such a system in place by year end.

11. Child Health Plus

By December 1992, there were 36,435 children enrolled in Child Health Plus. Enacted by Chapters 922 and 923 of the Laws of 1990, Child Health Plus provides subsidized primary and preventive health insurance coverage to uninsured and underinsured children up to age 13 who are not on medical assistance and who reside in households in which gross income is less than 222% of the federal poverty level. Several insurers temporarily suspended new enrollments while the Departments of Health and Insurance negotiated premium rate increases for the program period of July 1, 1992 through June 30, 1993. The experience for some insurers has not been favorable, necessitating greater premium rates which would be, in part, subsidized by the Statewide Bad Debt and Charity Care Pool.

The following insurers, health maintenance organizations and prepaid health services plans participate in Child Health Plus. The number of enrollees is based on Department of Health data:

Table 35
CHILD HEALTH PLUS
Participants, Service Area, Enrollment
(as of December 1, 1992)

Participant	Geographical Service Area	Enrollment
Blue Cross and Blue Shield of Central New York, Inc.	Broome, Cayuga, Chemung, Cortland, Madison (west), Onondaga, Schuyler, Steuben, Tioga, Tompkins and Yates counties	2,672
Blue Cross and Blue Shield of the Rochester Area	Livingston, Monroe, Ontario, Seneca and Wayne counties	3,239
Blue Cross and Blue Shield of Utica-Watertown, Inc.	Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, (east), Montgomery, Oneida, Oswego, Otsego and St. Lawrence counties	3,010
Blue Cross and Blue Shield of Western New York, Inc.	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties	2,556
Blue Shield of Northeastern New York, Inc.	Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties	927
Bronx Health Plan	Bronx	301
Capital Area Community Health Plan, Inc.	Albany, Clinton, Columbia, Dutchess, Fulton, Greene, Montgomery, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren and Washington counties	2,186
Centercare PHSP	Manhattan	811

Participant	Geographical Service Area	Enrollment
Empire Blue Cross and Blue Shield	Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Montgomery, Nassau, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester counties and New York City	11,466
Group Health, Inc.	Bronx	1,243
Health Care Plus	Brooklyn	2,894
Health Insurance Plan of Greater New York, Inc.	Queens, Suffolk and Nassau counties	3,652
Westchester PHSP	Westchester County	1,347

Based on Health Department data, 61.7% of the children enrolled were at 120% to 160% of the federal poverty level, 12.1% of the children were in the 160% to 222% range and 25.8% of the children were from families that fall below the 120% level.

12. Regional Pilot Projects

Chapter 703 of the Laws of 1988 authorized the development of a program to test on a limited regional basis health care coverage models to provide insurance to uninsured individuals and small employer groups. The premium charged for coverage available under the pilot projects is subsidized from an annual distribution of funds from the Statewide Bad Debt and Charity Care Pool.

In 1992, two HMOs, (Capital Area Community Health Plan and Health Insurance Plan of Greater New York) one prepaid health services plan (The Bronx Health Plan) and one insurer (Empire Blue Cross and Blue Shield) participated in five Regional Pilot Projects. Three of the Projects are individual subsidy programs and two are small employer group programs. Based on Department of Health data, total enrollment in all Plans as of December 1, 1992 was 12,939.

13. Life Care Communities

Significant progress toward the establishment of a life care industry in New York was made in 1992. The Life Care Council conducted a formal review of an application for a certificate of authority to build and operate a life care community in New York and granted a conditional certificate. Final approval is to be given upon resolution of certain aspects of the actuarial documentation associated with the reserve calculations and rating methodology, certain clarifications in the life care contract, the escrow agreement, and certain other matters relating to concerns raised by the Health Department.

The Insurance Department was involved in the review process and the negotiations leading to the final approval. The Department is primarily responsible for the review of the reserve and supporting asset documentation, the rates and rating methodology, the legal sufficiency of the life care contract and the disclosure documents given to residents and prospective residents.

The Insurance Department was also chosen as a member of the subcommittee of the Life Care Council established to review the progress of the industry in New York and to make recommendations to the Council for legislative changes or other actions that would foster development of the industry. Specific recommendations were made to the Council concerning the use of escrowed resident deposits during the construction phase of a life care community, the charging of a nonrefundable application fee, broadening the scope of sponsors of life care communities permitted to operate associated adult care facilities to include for profit entities, and allowing different types of communities with different benefit packages to qualify under the life care statute. With the exception of the use of escrowed entrance fee deposits, all of the proposals were included in proposed legislation that will be pursued in the 1993 legislative session.

The principal cause for the delay in the establishment of a viable life care industry in New York is the lack of available financing. The economic climate is such that there is very limited commercial financing available to prospective operators. With the well publicized problems of banks relative to their real estate loan portfolios, there is little interest in financing new ventures in an industry with no track record in New York. Tax-exempt financing is not a currently viable option due to the Public Authority Control Board policy requiring all public bonding authorities to issue only bonds with an investment grade rating. It is not feasible for most of the prospective operators to obtain the credit enhancement necessary to obtain the required investment grade rating. The Insurance Department is participating in a series of meetings, together with the Health Department, prospective operators, and other Life Care Council members, designed to explore the availability of financing. The Department met with representatives of commercial funding sources, U. S. Department of Housing and Urban Development (HUD), the NYS Dormitory Authority, NYS Medical Care Facility Financing Agency (MCFFA), NYS Housing Financing Agency (HFA), State of New York Mortgage Authority (SONYMA), Fitch Rating Service and the Public Authority Control Board. Additional meetings are planned for 1993.

Several other potential sponsors of life care communities have made contact with the Insurance Department to discuss proposals. An additional application has been filed with the Life Care Council and other applications are contemplated. The Department remains committed to fostering this industry in New York.

14. Future Care Planning

Pursuant to Chapter 516 of the Laws of 1991, the Insurance Department was a member of a task force chaired by the Office of Mental Health that included as other members the Office of Mental Retardation and Developmental Disabilities, the Department of Banking, and the Department of Social Services. The January 1992 Report to the Governor and the Legislature entitled Future Care Planning prepared by the Office of Mental Health made recommendations on the appropriate course of action for the State of New York to take in order to provide options for families with members who have mental illness or developmental disabilities. Many such families are concerned with the problems of continuing care and oversight when they are no longer able to provide such care and need assurance that funds provided by relatives of the disabled individual will be managed properly and used for the benefit of that individual without impairing his or her entitlement to government benefit programs for basic support and care.

It is expected that one of the principal methods of funding future care needs will be through a supplementary needs trust established in accordance with the Escher doctrine (In matter of Escher, 94 Misc 2d 952, aff'd 52 NY 2d 1006). Such doctrine prevents invasion of a trust in order to provide the basic support needs of the trust beneficiary notwithstanding Section 7-1.6 of the Estates, Powers and Trusts Law. If such trust gives the trustee full discretion to distribute or retain income other than for basic support that is provided by government programs, such trust assets cannot be invaded and can be applied for the sole purpose of supporting the supplemental needs of the disabled person including future care planning, advocacy and case management. The Report concluded that legislation is necessary to provide a "simple, effective and stable program by which families may set aside funds to generate income that will pay for other entities to provide this supplemental service ...without jeopardizing the disabled person's government benefits." A stable program necessitates the need to codify the Escher doctrine, thus assuring families that any assets set aside for the future care of their disabled family members would not be invaded by government authorities pursuant to Section 7-1.6 of the Estates, Powers and Trusts Law.

One possible funding mechanism is life insurance purchased on the life of the family member who will establish the supplementary needs trust for the disabled individual. It is possible that organizations that will provide supplementary care, case management and advocacy for the disabled may be named as a beneficiary of the trust corpus upon death of the disabled individual.

15. Accelerated Death Benefits

Pursuant to Chapter 428 of the Laws of 1991, the Department promulgated Regulation 143 (11NYCRR 41) on April 27, 1992. The Regulation, which became effective on May 13, 1992, sets forth the rules for the accelerated death benefit provisions under an individual or group life insurance policy or fraternal benefit certificate. Proceeds under a life insurance policy may be payable in part or in full upon the diagnosis of terminal illness resulting in a life expectancy not to exceed 12 months or upon the diagnosis of a medical condition requiring extraordinary medical care or treatment regardless of life expectancy.

Insurers that choose to make the accelerated death benefit available must comply with the standards in Regulation 143 for advertising, disclosure, benefit levels, benefit eligibility, nonforfeiture benefits and policy reserves. The regulation provides for extensive disclosure to the consumer concerning the effects of accelerating part or all of the policy's death benefit. In addition, consumers are provided notification that other means may be available for providing access to a policy's values, that receipt of benefits may affect eligibility for public assistance programs and may be taxable, and that such benefits should not be considered as an alternative to long-term care health insurance.

Regulation 143 defines the phrase "medical condition requiring extraordinary medical care or treatment regardless of life expectancy" as set forth in Section 1113(a)(1) of the Insurance Law, as amended by Chapter 428, by requiring that the accelerated benefit policy provisions set forth specific medical conditions eligible for accelerated payment that may include one or more of the following:

- coronary artery disease resulting in acute infarction or requiring surgery;
- permanent neurological deficit resulting from a cerebral vascular accident;
- end stage renal failure;
- acquired immune deficiency syndrome;
- major organ transplants; or
- other medical conditions that the Superintendent shall deem appropriate.

The recognized medical conditions requiring extraordinary medical care or treatment are the same conditions recognized in the National Association of Insurance Commissioners Model Regulation for accelerated life insurance benefits.

Regulation 143 specifically recognizes three product designs:

- discounted payment of the face amount;
- policy loan or lien against the policy up to the face amount; and
- the additional premium for full payment up to the face amount.

Regulation 143 provides that a life insurance policy may provide for acceleration of up to 100% of the death benefit, but the policy must provide the right of the policyowner to request a partial accelerated death benefit that may not be less than the lower of 25% of the face amount or $50,000 but not greater than 50% of the face amount. The Regulation also permits election of the payment of accelerated death benefits in installments, but not less frequently than quarterly, provided that each installment is not less than 25% of the actual amount accelerated by the policyowner. This restriction should minimize misuse of the accelerated death benefit as a form of long-term care insurance or nursing home confinement benefit.

Since the effective date of the Regulation, 15 insurers received approval of accelerated death benefit riders or policies and nine insurers have received approval of group accelerated death benefit products.

In December, the Internal Revenue Service (IRS) issued a proposed regulation relating to the definition of life insurance for federal tax purposes and to the federal income tax treatment of life insurance proceeds received as qualified accelerated death benefits. The proposed IRS regulation will provide insurers with the standards needed to design and market life insurance contracts that provide accelerated death benefits without subjecting the life insurance policyholder to taxation on the cash value build-up of the life insurance contract. More specifically, the proposed regulation will permit the payment of benefits prior to death without any income tax liability to the recipient if death is expected to occur within 12 months. It appears that the standards set forth in Chapter 428 of the Laws of 1991 and Insurance Department Regulation 143 are consistent with the proposed federal tax regulation which should become effective sometime in mid-1993.

16. Group Annuity Contracts and ERISA

There have been several conflicting Federal Circuit Court decisions involving lawsuits between life insurers and certain pension plan policyholders on the issue of whether the fiduciary responsibility provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as amended, 29 U.S.C. Sections 1001-1426, should be applied to general account assets of insurers. The Second Circuit Court of Appeals recently ruled that John Hancock Mutual Life Insurance Company is an ERISA fiduciary for the nonguaranteed portion of a general account group annuity contract.

As such, John Hancock will be required under the "exclusive benefit" rule (Section 404(a)(1) of ERISA) to manage its general account assets solely for the benefit of pension participants and their beneficiaries. This presents a fundamental conflict with regulation of insurance because state insurance laws require an insurer to treat all policyholders fairly and equitably. This decision, if upheld by the U.S. Supreme Court, will interfere with the nondiscriminatory treatment of policyholders required by state insurance laws and conflict with numerous State court decision involving a mutual insurer's responsibility in treating its general account policyholders in a fair and equitable manner. The decision will also interfere with the states' ability to ensure the financial stability of insurance companies, particularly if the decision should be implemented on a retroactive basis to all pension contracts. The decision disrupts the pooling of risks that occurs in an insurer's general account where each policy has a risk assumed by the insurer that in turn is shared by all other policyholders.

The Department previously attempted to balance the interests of pension plan group annuity general account policyholders with all the other general account policyholders by promulgating Regulation 139 (11 NYCRR 40) in 1990. Regulation 139 prescribes certain rules for the protection of pension plan policyholders (and plan participants); however, it does so within the context of State regulation in a fair, equitable and nondiscriminatory manner with all the other general account policyholders. The Regulation does not give favored treatment to pension plan policyholders at the expense of other policyholders which the decision in Harris Trust may well do if upheld upon appeal to the U.S. Supreme Court.

17. Credit Rating Downgrade Bailout Provisions in Annuity Contracts

The Department released Circular Letter No. 2 (1992) on March 17, 1992 advising life insurers writing annuity contracts and funding agreements in conjunction with qualified pension plans that the Department will not approve a provision waiving surrender charges or negative market value adjustments in the event that the insurer's credit rating is lowered by one or more private credit rating agencies.

In light of the United States Department of Labor's tentative guidelines that pension plan sponsors and fiduciaries should only invest pension assets with insurers assigned high credit ratings, some sponsors requested incorporation of provisions into group annuity deposit administration contracts and guaranteed interest contracts (GICs) that would permit the cash surrender without imposition of any adjustments or surrender charges in the event the insurer's credit rating is downgraded due to some financial difficulty. The primary cause for such financial difficulty has been nonperforming commercial real estate properties and commercial mortgages held by insurers.

The Department stated that waiver of surrender charges or market value adjustment provisions designed to protect against risks associated with anti-selection and disintermediation would be unfair, unjust and inequitable to persisting policyholders who would be required to subsidize the withdrawal activity of terminating pension plan contractholders. Additionally, the actual exercise of such waiver provision by a few large contractholders could result in a panic run of all policyholders causing liquidity problems or severe investment losses if assets are forced to be sold at depressed market values. While an insurer may undergo financial stress in the event of a credit rating downgrade, the existence of a credit rating bailout provision in group annuity contracts can only increase financial problems and possible regulatory intervention under Article 74 of the Insurance Law.

18. Professional Health Service Charges for Automobile No-Fault

The Bureau worked on the development of the Nineteenth Amendment to Department Regulation 83, establishing revised fee schedules for medical and other professional health services payable under automobile no-fault insurance. The Nineteenth Amendment was promulgated as an emergency measure on August 19, 1992 and promulgated as a final Regulation pursuant to Chapter 892 of the Laws of 1977, the Comprehensive Motor Vehicle Insurance Reparations Act. The Nineteenth Amendment adopted the revised fee schedules as established by the Chairperson of the Workers' Compensation Board for industrial accidents covering medical and chiropractic services provided on or after September 1, 1992. The Amendment also revised existing maximum fee schedules established by the Department for other professional health services provided on or after September 1, 1992. In addition, the Bureau worked with the Department of Health in distributing updated values for diagnosis-related groups (DRGs) for hospital inpatient reimbursement as it pertains to no-fault automobile insurance.

D. PROPERTY AND CASUALTY INSURANCE BUREAU

1. Filings Involving Rates, Rating Rules, Policy Forms, Rate Classifications and Rating Territories

There were 7,072 filings involving changes in rates, rating rules, policy forms, rate classifications and rating territories submitted by rate service organizations, joint underwriting associations and companies during 1992. The filings were for the following:

	Number of Filings			
Line of Business	Rates & Rules	Forms	Classes & Territories	Total
Fire and Allied Lines	237	183	37	457
Farmowners Multiple Peril	54	29	0	83
Homeowners Multiple Peril	206	163	20	389
Multiple Line	90	120	18	228
Commercial Multiple Peril	420	322	52	794
Inland Marine	204	174	4	382
Medical Malpractice	216	95	12	323
Earthquake	4	7	0	11
Rain	0	0	0	0
Workers' Compensation & Employers' Liability	168	84	3	255
Other Liability	1,158	858	136	2,152
Motor Vehicle Insurance	892	470	77	1,439
Aircraft	3	8	0	11
Fidelity & Surety	110	37	1	148
Glass	46	6	0	52
Burglary & Theft	100	39	18	157
Boiler & Machinery	31	18	0	49
Credit	4	5	0	9
Animal Mortality	3	2	0	5
Mortgage Guaranty	13	11	0	24
Residual Value	1	1	0	2
Title	3	19	0	22
Group Property/Casualty	32	26	2	60
Financial Guaranty	5	15	0	20
Total	4,000	2,692	380	7,072

These figures do not include approximately 55,000 individual risk filings received during the year. They do, however, include approximately 400 consent-to-rate filing applications, 250 manuscript policy filings and 200 rating plan filings submitted in 1992. Forty-one form filings, three rating classification or territorial filings and 35 rate or rating rule filings were disapproved during 1992.

Table 36
MAJOR EFFECTS OF PRINCIPAL RATE CHANGES FILED IN 1992 BY PROPERTY AND CASUALTY RATE SERVICE ORGANIZATIONS

	Percent Changes in Average Statewide Rates
Automobile	
Automobile Insurance Plans Service Office	
Private Passenger Automobile	
Bodily Injury Liability	+10.3
Property Damage Liability	0.0
Personal Injury Protection	+27.0
Uninsured Motorists	+15.4
Comprehensive	0.0
Collision	- 5.0
All coverages total	+ 9.5
effective September 1, 1992	
Fire and Allied Lines	
Underwriters Rating Board	
Commercial Fire	
Class Rates and Manual Revised	-12.9
effective January 1, 1993	
Liability Other Than Auto	
Insurance Services Office, Inc.	
General Liability	
Premises/Operations Liability	
Products/Completed Operations Liability	
Increased Limits Factors Revised	-12.0
effective July 15, 1992	
Underwriters Rating Board	
General Liability	
Premises/Operations Liability	
Owners, Landlords and Tenants	
Rates Revised	+23.0
effective July 1, 1992	

General Liability

Products Liability Rates Revised effective July 1, 1992	+ 5.8

Surety

Surety Association of America Signature Guarantee Bonds Rates	New

2. Rate Service Organizations

a. Insurance Services Office

The Insurance Services Office (ISO), the largest rate service organization in the United States, with approximately 1,200 New York members and subscribers, announced during 1989 that beginning in January 1990, it would no longer provide advisory rates except under limited circumstances. Instead, ISO would only provide its member companies with prospective loss costs, or estimates of future loss payments for various property and casualty insurance products. The companies would then add their own expense factor to the loss-cost in establishing a rate.

In order to accommodate utilization of prospective loss costs and conversion of such loss costs into final rates, and to facilitate insurer compliance with governing provisions of Article 23 and Regulation 129, the Insurance Department changed the reporting requirements and forms previously in use. On October 30, 1992, the Department issued Circular Letter No. 19 prescribing new forms to be used to accommodate loss-cost filings.

b. The Surety Association of America

The Surety Association of America informed the Department on September 20, 1990 that its Board of Directors had voted unanimously to discontinue developing and filing rates and would begin a period of transition for conversion to loss costs. We were advised that the Association was making preparations to begin filing a new Loss Cost Manual of Rules and Procedures for Fidelity, Forgery and Surety Bonds in states where existing laws specifically disallow the filing of end rates. The Association made only one major filing during 1992 which was a bond program for financial institutions guaranteeing the signature of securities transfer endorsers. This was not made on a loss-cost basis.

c. Title Insurance Rate Service Association

There has not been a title insurance rate service organization in New York since 1985. Because the title insurance industry was concerned about a Federal Trade Commission investigation relating to title insurance rating practices in other states, the New York Board of Title Underwriters decided to surrender its license at that time. In fact, since 1983 no industry-wide title insurance statistical data have been compiled nor have rates been changed. The establishment of a rate service advisory organization was critical in light of an overall incurred loss ratio for title insurance that climbed from 5% in 1988 to 15% in 1990 while paid losses nearly doubled over the same period. The Department therefore licensed the Title Insurance Rate Service Association (TIRSA). Following a public hearing held in February 1991 details of the action were contained in a Memorandum Opinion and Decision dated November 19, 1991.

On July 7, 1992 the Department approved a statistical plan submitted by TIRSA for the collection of data from member companies, to be used for the purpose of establishing rates. This is the first time in nine years that such data are being collected on a uniform basis.

At the request of the State Division of the Budget, the Department provided technical expertise in the preparation of a proposed Budget Bill concerning security deposits held by title insurers and their agents or representatives. The proposed bill would amend the Insurance Law by adding a new Section 6412 prescribing implementation of a standard security deposit agreement that contains specific reporting requirements as well as notifications to lien holders. The proposed bill would also amend the Abandoned Property Law by adding a new section that considers funds held by title insurers for more than three years to be abandoned property The objective is to have monies held in escrow by the title insurance community, i.e., underwriters and agents, promptly moved to the proper parties.

During 1992 representatives of the Department organized and participated in a task force comprising representatives of the title industry and the City of New York primarily for the purpose of resolving problems concerning security deposits for liens owed to New York City held by title insurers. After several meetings, an agreement was reached regarding procedures for new liens. However, a procedure for liens outstanding have not been established.

To determine the extent of escrow funds being held, the Department requested information from the title industry concerning amounts and types of escrow deposits held by both underwriters and agents. This information is currently being compiled.

On December 14, 1992 the Department issued Circular Letter No. 18 advising each authorized title insurer in New York State that it should not issue closing protection letters (CPLs) in the future with respect to New York real property transactions and that it should rescind any blanket CPLs as to future transactions.

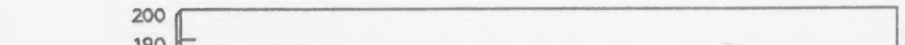
Under a CPL, the title insurer purports in effect to indemnify the lender (mortgagee) in the event of losses caused by any improper acts or omissions, not by the title insurer's agent, but by the lender's attorney, in connection with the underlying real property transaction. As such, the CPL is in the nature of fidelity or surety coverage, or resembles professional liability insurance against legal malpractice on the part of the lender's attorney. As a rule, a title insurer lacks authority to issue a CPL to a lender insofar as that lender's attorney is concerned because its purported protection falls beyond the scope of the monoline title insurer's license and writing authority.

In order to enhance our understanding of issues confronting the title industry, the Department formulated a title insurance industry advisory committee, consisting of title insurance agents, underwriters and other interested parties. The working group under the auspices of the Department has been asked to provide advice and guidance to the Superintendent on various key title insurance issues and questions confronting the title insurance industry. During 1992 four meetings were held and the topics discussed included: NAIC title insurance developments; closing protection letters; Schedule N and other related security deposit issues, and the necessity for new title insurance on a refinance.

3. New York Property Insurance Underwriting Association

The following graph illustrates the number of policies issued by the New York Property Insurance Underwriting Association since 1970:

NYPIUA – Policies Issued 1970 to 1992



Following the peak year 1971 (182,000 policies), there was a steady decline through 1977 in the number of policies issued annually by the Association. The period 1977 through 1982 saw comparative stability, with the number of policies ranging between 94,000 and 105,000. The sharp decline experienced from 1982 to 1983 can be attributed to soft market conditions, while 1986 showed a sharp increase in policies issued as the voluntary insurance market hardened. Another soft insurance market accounted for the large decrease in the number of policies issued by the Association starting in 1989 and continuing through 1992 as many NYPIUA policies were rewritten in the voluntary market.

For the calendar year ending December 31, 1992, the Association's Financial Report indicated premiums earned of $26,369,798 and a net underwriting loss of $3,357,596. Other income of $3,813,164--comprised of net investment income of $3,299,567, $90,778 in premium balances charged off, bond amortization loss of $252,575, gain on sale of securities of $802,294, and income from data processing services of $54,656--resulted in net income before taxes of $455,568. The change in assets not admitted of $68,011 and distribution to member companies of $9,741,483, resulted in a reduction in the Members' Equity Account of $9,217,904.

The cumulative operating profit as of December 31, 1992 was $30,961,244. After all assessments (net of distribution of $28,671,815), the net Members' Equity Account totaled $2,289,429.

In accordance with Section 5405(c) of the New York Insurance Law, the Association concluded that even though it estimated a deficit from operations of $1,791,000, there will be no need to credit the Association with any funds from the New York Property/Casualty Insurance Security Fund for the year beginning January 1, 1993, since Association assets exceed liabilities. After the Department's review of the data submitted, it was determined that there would be an operating deficit of $1,170,000 from the operations of NYPIUA. In view of these results, no estimated deficit from operations was approved for the Association for the calendar year ending December 31, 1993.

For four consecutive years (1986-1989), NYPIUA made special distributions to its commercial policyholders, totaling $26 million, because of the favorable underwriting results those policies attained during those years. However the underwriting results for 1990 and 1991 were not as favorable and therefore did not warrant distributions. If underwriting results improve in the coming years, further distributions will be made to those classes generating favorable results.

In a related matter, the Department approved the final close-out of NYPIUA policy year 1988 as well as the provisional 60% close-out of policy year 1989, pursuant to the revised close-out formula approved by the Department in December 1988. The close-outs resulted in a distribution to member companies of $10,828,782 in 1992.

The Insurance Services Office did not make any dwelling or commercial fire rate revisions during 1992. Because of this, NYPIUA made no rate filings during the year.

4. Federal Insurance Programs

Legislation was passed by Congress and signed by the President in 1991 extending authorization to September 30, 1995 for both the Federal Crime and the National Flood Insurance programs. The Department was pleased that both Congress and the President had the foresight to extend both of these vital programs.

Over the past several years natural disasters have occurred across the country causing financial strain on the insurance industry as a whole and also causing hardship to both business owners and homeowners. Given the prevailing natural and economic conditions, voluntary or other insurance markets in addition to the ones already established may be needed to fill the insurance voids. The active participation of individual states in the development, control and operation of these programs will be necessary in the future.

The following tables show the policies in-force and the loss experience of the Federal Crime Insurance Program as of December 31, 1992:

Table 37
FEDERAL CRIME INSURANCE PROGRAM
Policies in Force, 1991-1992

	Number of Policies		
New York City	12-31-92	12-31-91	% Change
Residential	6,555	7,274	- 9.9%
Commercial	2,065	2,518	-18.0%
Total	8,620	9,792	-12.0%
Remainder of State			
Residential	1,057	1,115	- 5.2%
Commercial	120	141	-14.9%
Total	1,177	1,256	- 6.3%
Total New York State	9,797	11,048	-11.3%
Remainder of U.S.	8,924	9,461	-5.7%
	18,721	20,509	-8.7%

Table 38
FEDERAL CRIME INSURANCE PROGRAM
Loss Experience, 1992

Loss Experience for 12 Months Ended 12-31-92

			Loss Ratio	
	Premiums	Losses	Current Period	1 Yr. Ago
Residential				
New York City	$ 713,399	$ 281,459	39.5 %	44.1 %
Remainder of State	114,257	18,208	15.9 %	19.3 %
Total	$ 827,656	$ 299,667	36.2 %	40.8 %
Commercial				
New York City	$2,334,772	$2,461,805	105.4 %	139.3 %
Remainder of State	124,744	110,480	88.6 %	40.8 %
Total	$2,459,516	$2,572,285	104.6 %	134.3 %
Total New York State	$3,287,172	$2,871,952	87.4 %	111.5 %
Remainder of U.S.	2,079,875	1,219,743	58.6 %	55.3 %
Total U.S.	$5,367,047	$4,091,695	76.2 %	90.0 %

5. Insurance Availability Problems

The general easing of availability problems in the liability insurance market continued in 1992. Activity in the following market assistance mechanisms established by the Department reflected this softening of the insurance marketplace:

a. General Liability Telephone Hotline

This service, instituted in 1985 to provide the public with information concerning the availability and affordability of liability insurance, was discontinued in January 1992. The Hotline had received 177 telephone calls in 1991, a significant drop from the 4,174 calls received in 1986, the apex of the liability crisis. Inquiries that previously had consumed the Department's time and resources on the Hotline were processed via the Bureau's regular telephone network. This is a reflection of the overall softening of the marketplace during the past six years.

b. Availability Survey

In response to the liability insurance crisis of the 1980s, the Department conducted special surveys to ascertain the existence of markets for difficult- to-place insurance coverages. As a result, markets for many of these risks were identified and, where a meaningful market did not exist for critical coverages, voluntary market assistance programs were successfully developed.

When information from various sources (such as correspondence and telephone inquiries) indicates that some markets have improved while new problem areas are identified, the annual survey is revised to request the most relevant information. Consequently, more meaningful information is included in each year's survey results.

The survey questionnaire of insurance market conditions and trends is distributed to licensed property/casualty insurers, accredited reinsurers, and producer organizations in an attachment to an annually updated Supplement 2 to Circular Letter No. 3 (1986) - Insurance Availability. The Department expanded its survey for 1990 to include a more comprehensive list of coverages. Following an analysis of the insurance availability survey, the Department compiled a listing of available markets for each type of risk specified in the survey.

Capturing the data contained in the 33-page survey completed by approximately 300 companies was a voluminous task and consumed a considerable amount of time. Our effort resulted in a 755-page report that we use to access market information regarding 265 different types of liability insurance risks, including the extent of availability for each category of risk addressed in the survey, and the means by which each company offering such coverage may be contacted.

The availability survey is an ongoing project. As the final results for one year are analyzed and compiled, updated questionnaires are prepared and distributed in anticipation of the next year's survey. In order to reduce the time and effort expended in the completion of this task, the Department has revised the method of data capture to introduce optical character reader technology. The Department issued Supplement 3 to Circular Letter No. 3 (1986), on July 10, 1992, to advise insurers of this change. Additionally, Standard Industrial Codes (SICs) published by the Executive Office of the President, Office of Management and Budget, were adopted to facilitate statistical analysis in our mainframe data base. In order to allow insurers sufficient lead time in implementing the changes in formatting, completed survey forms, normally due by October 1, are not due until March 1, 1993.

c. Police Professional Market Assistance Program (PPMAP)

At year-end 1992, the PPMAP, in which 20 carriers participate on a voluntary basis, had three policies in effect for various police departments throughout the State, a decrease of four policies from the previous year. There were no calls received regarding police professional liability insurance during 1992, which indicates that the problems in obtaining this coverage have continued to ease.

The Department, in a coordinated effort with the National Union Fire Insurance Company of Pittsburgh, Pa., the lead writer and administrator of the PPMAP, attempted again to place the program into cessation during the summer of 1992. As a result of these concerted efforts, which included telephone surveys of producers and insurers, four of the seven insureds were successfully placed in traditional voluntary markets. Three insureds do remain in the program and still cannot find coverage. Therefore, the PPMAP has been kept open.

d. Family Day Care Market Assistance Program (FDCMAP)

On August 1, 1988, the Family Day Care Market Assistance Program (FDCMAP) was established to enable licensed providers of both family day care (three to six children) and group family day care (seven to twelve children) services in a private home to obtain affordable liability insurance coverage.

In order to qualify for FDCMAP placement, family day care providers must comply with governing rules and regulations, including licensing and registration requirements, issued by the State Department of Social Services and relevant local agencies, such as the New York City Health Department and county social services agencies.

Aetna Casualty and Surety Company acts as the servicing carrier for the FDCMAP, through which 15 insurers participate by sharing risks under a quota-share arrangement.

There is no application fee for the FDCMAP, which provides liability coverage on an occurrence basis. In addition to basic $5,000-per-child medical payments coverage, the provider may choose from minimum liability limits of $100,000 per occurrence/$300,000 per year up to $500,000/$1,000,000 maximum limits.

The Department prepared a brochure explaining how family day care providers can obtain liability insurance coverage through the FDCMAP. The brochure was sent to the Department of Social Services for distribution through its network of local offices. The brochure is also available free of charge through the Insurance Department.

There have been 114 policies issued in the FDCMAP from its inception through 1992, with 72 policies active at year-end.

e. Petroleum Distributors and Dealers

(i) The significant financial responsibility requirements imposed by the federal Environmental Protection Agency (EPA) became effective on April 26, 1991 for owners and operators of 13-99 underground storage tanks (USTs). Requirements for those with 1-12 tanks were scheduled to do so by October 26, 1991. However, in recognition of the likelihood that most of these distributors and dealers would be unable to comply, the EPA first postponed the deadlines to December 31, 1991, and after further review recently postponed it until December 31, 1993. In the Department's view, the supply of such insurance will not be sufficient to meet the demand in this State. The Department has been working with the Legislature, the New York Department of Environmental Conservation and other responsible parties to develop workable approaches to pollution problems for all types of exposures. However, those involving underground storage tanks remain in the forefront.

(ii) As mentioned elsewhere, the Department, by issuing the Fifth Amendment to Regulation 107, bridged the conflict between Regulation 107 provisions and the financial responsibility requirements of the federal Environmental Protection Agency. The federal requirements do not allow for a defense cost provision to be included within the policy limit. The Fifth Amendment to Regulation 107 permits policies with a separate defense limit to be written for underground storage tank coverage. Such policies must provide that:

- there be per claim limit of liability;
- annual aggregates may only be issued in accordance with the schedule contained in the Regulation, based upon type and size of the facility;
- the per claim limit and any aggregate limit may not be reduced by the payment of legal defense costs;
- the separate defense limit must:

  (A) apply to each claim in an amount at least 50% of the per claim liability limit applicable to such claim;

  (B) for policies without aggregate limits, apply to all claims in an amount at least equal to the per claim limit of liability; or

  (C) for policies with aggregate limits, an option must be offered to the insured of obtaining a separate defense limit in an amount equal to at least 50% of the annual aggregate limit and apply to all claims in an amount equal to the greater of 25% of the annual aggregate limit or $500,000.
- after any applicable limits are exhausted, the insurer shall pay no further defense costs even if the separate defense limit has not been exhausted.

The passage of this regulatory amendment has led directly to the approval of UST insurance programs by this Department for two major players in this market--Chubb Insurance and the Fireman's Fund Insurance companies.

(iii) The Department continues to participate in the activities of the National Association of Insurance Commissioners' (NAIC) Environmental Liability Insurance Task Force, studying methods that can be used to make these exposures more insurable, including the development of acceptable policy language.

f. Lead Liability Exclusion

Several insurers providing a much needed market for commercial liability insurance in urban areas have introduced policy exclusions for damages arising out of exposure to lead. The exclusions are generally applicable to structures built prior to 1980 (when regulations eliminating lead paint were enacted). The Department, while conscious of the hardships that this may impose upon building owners, is also aware of the problems that insurers are faced with as a result of the severity of claims in this area.

The Department has convened a task force made up of industry and Department personnel to study the problem and find solutions. The Department is also interfacing with the Department of Health and the Legislature on this problem.

6. Standby JUA Authority

The Omnibus Liability Bill enacted in June 1986 was extended in 1988. Among other provisions, the Bill granted the Superintendent of Insurance the authority to activate a mandatory Joint Underwriting Association (JUA) whenever, after a public hearing, he determines that there is no meaningful market available for a line of insurance.

Coverages have remained generally available; however, again in 1992, difficulties arose in obtaining coverages for some small and unique exposures for which the marketplace is limited. With the cooperation of the industry, the Department was able to place these coverages. Therefore, no hearings were held to determine the need for the enactment of a JUA for any markets. The standby authority does, however, remain a valuable mechanism for providing coverage in the event that difficult markets develop.

7. Bonding and Insurance for Small and Minority Contractors

Small and minority contractors across the State are faced with the continuing problem of obtaining adequate bonding and insurance. In order to establish a more efficient system of assistance to small contractors, the Insurance Department has worked with the Department of Economic Development to afford small contractors easier access to technical assistance and other help. The Department also has been working with the Surety Association of America (SAA) to increase the availability of surety bonds to small contractors. A modernized rating approach, designed to yield the issuance of more small contractor bonds, continues to be monitored on an experimental basis.

The Department established a Help-Line in 1988 to assist small contractors and minority business owners having difficulty obtaining the bonding required to effectively compete in their respective fields.

The Bond Assistance Program of the Surety Association of America has been continued in an effort to assist contractors that have difficulty obtaining surety bonds. This program is operated in conjunction with the National Association of Surety Bond Producers and the American Subcontractors Association.

The Department participated in a bonding task force on small, minority- and women-owned businesses in construction, sponsored by the New York State Urban Development Corporation and the New York State Job Development Authority, which was jointly chaired by the New York Building Congress and the Regional Alliance for Small Contractors. The purpose of the task force was to recommend sound public policy and eliminate barriers to the growth of women- and minority-owned businesses in construction.

Some of the advances made on this project were:

- a streamlined application process;
- specially designed underwriting guidelines;
- insurers and producers to inform bond applicants of reasons for rejection and suggest methods to improve bondability; and
- institution of an educational program for contractors, whereby workshops will be held on recordkeeping, reporting organization of data and preparation of bonding applications.

8. Surety Bonds on New York City Projects

The Department met with representatives of several New York City agencies and insurers to explore procedures that might be implemented to expedite the payment of performance bonds when contractors default on city projects. As a result, improvements in communication and in the exchange of information have been developed between the various city agencies and several leading bond carriers which should enhance the payment of claims.

9. Attorneys' Bonds

The New York State Bar Association administers the Lawyers' Fund for Client Protection of the State of New York, which is used to reimburse victims of attorney abuse of fiduciary responsibilities to clients. The Bar Association is concerned that the Client Fund may not be adequate to cover the rising trend in claims.

The Department participated in the development of legislation in the Assembly that would require attorneys who hold monies in escrow to post a bond as protection for their clients against the misappropriation or theft of funds.

10. Wrap-Up Insurance for Public Works Projects

The Department continues to support changes in the permissibility of wrap-up insurance for public entities. Wrap-up policies are often used to insure all of the various contractors and subcontractors that are involved in major construction projects for their collective general liability and workers' compensation insurance exposures. In the absence of wrap-up insurance, each contractor and subcontractor must provide its own liability and workers' compensation insurance, resulting in overlapping and duplicate coverage at a much higher cost. These higher costs are ultimately borne by a project's sponsor (i.e., the state or local government authority).

While wrap-up policies have been used in private construction projects for more than 30 years, the provisions of Section 2504 of the Insurance Law which were transferred from the Penal Law in 1958 have barred such mechanisms from being used to insure state and locally sponsored projects. However, over the years, a number of exemptions from the provisions of Section 2504 have been enacted permitting some limited public works projects to be insured under wrap-up programs. The Port Authority and the Metropolitan Transportation Authority are two recipients of such exemptions.

With the fiscal constraints currently facing both the State and local governments, increased attention has been focused on the prohibitions contained in Section 2504. The question of the statute's continuing pertinence has been raised, and both the proponents and opponents of relaxation of the current prohibitions make strong arguments supporting their positions. A bill to amend Section 2504 was introduced during the 1990 Legislative Session and supported by the Department. The legislation failed but was reintroduced in the 1991 and 1992 Sessions. The Department continues to believe that wrap-up insurance will be a cost-saving device for various city and state agencies.

11. Gap Insurance

The Department continues to investigate all aspects of so-called Gap Insurance sold in connection with leased vehicles. Such insurance is being offered in the marketplace which may not be permitted under the Insurance Law as it is currently structured. It covers the remaining balance of a lease after the collection of the loss under a physical damage auto policy in the event the leased vehicle is totally destroyed or stolen. Discussions are currently being held with the Office of the Attorney General regarding possible legislation, if needed, that would establish Gap Insurance as a permissible kind of insurance under Section 1113-a of the Insurance Law, and establish appropriate guidelines for such arrangements.

12. Liability Insurance for Asbestos Abatement Contractors

Problems related to current practices in the liability insurance market for asbestos abatement contractors, particularly those that bid on contracts with the City of New York, received the Department's attention during 1992.

Among the problems these contractors have faced are the placement of coverage out of state for risks primarily located in New York and deficiencies in the coverage provided, both from a regulatory standpoint and in terms of the meaningfulness of the policy provisions. An example of one of the latter issues is the apparent absence of coverage for abatement procedures involving the enclosure of contaminated material or for encapsulation of asbestos without its removal from the premises. In many instances, such methods are considered to be the preferred means of containing the environmental asbestos hazard.

Another problem involves the issuance of project-specific policies to individual contractors, which could lead to insufficient coverage for incidents involving routine general liability situations not directly related to the asbestos abatement activity.

The Department met with representatives of the New York City Department of Environmental Protection and with several insurers involved in this market (which has a limited number of participants) in order to address these concerns. As a result, a hybrid type of policy, which would be used to bridge all aspects of an insured's operations, as well as provide the necessary coverage for city projects, was developed and approved for the North American Specialty Company and the Reliance Insurance Company.

13. Employment Practices Liability Insurance

The Department has long held that insurance coverage for acts of discrimination is contrary to the public policy of this State. However, with the expansion of civil rights legislation (most recently the Federal Civil Rights Act of 1991 and the Federal Disabilities Act) and evolving judicial decisions in this area of the law over the past three decades, it has become apparent that substantial liability exposure is present even in cases where the unfavorable results are not the product of intentionally discriminatory practices on the part of the employer, but are the product disparate impact standards.

The Department has revisited this issue and reached the following conclusions:

- Coverage for acts of disparate impact may be provided. This will protect employers against such acts that may be dependent upon subjective interpretations of applicable laws, and the future judgment of its system based upon the needs of the workforce.

- Responsible underwriting of potential risks, and an insurer's participation in designing effective human resource management programs and procedures that will prevent incidents of unacceptable employment practices, may actually serve to reduce employers' liability exposure as well as improve conditions in the workplace.

- Willful acts of discrimination remain uninsurable.

14. New York Municipal Insurance Reciprocal

The Department provided technical assistance to the Municipal Reciprocal Steering Committee of the New York State Municipal Council whose purpose was to study the feasibility of forming a Municipal Insurance Reciprocal pursuant to Article 61 of the insurance law.

15. Governor's Council on Children and Families

The Department participated in a workgroup chaired by the Council on Children and Families formed to study insurance matters relating to the operations of state agencies, not-for-profit provider agencies and localities. The purpose of the workgroup was to identify:

- the current state mandates and reimbursement for insurance costs;

- the types of insurance that should be considered for group purchasing or other pooled arrangements;

- the provider networks that could benefit by shared purchasing:

- the role the State should play vis-a-vis existing purchasing groups.

As a result, a two-pronged strategy to contain the insurance costs of not-for-profit provider agencies has been developed. First, a program of group insurance for property, liability, workers' compensation and disability insurance will be structured. Second, the State will assess the possibility of opening up the State Health Insurance Program to not-for-profit agencies in order to take advantage of the benefits of the cost effective program.

Over the course of 1993, work will continue on this project, including:

- developing and implementing a process of collection of claims histories;

- setting up procedures for the administration of the program;

- preparation of a Request for Proposal.

16. Excess Workers' Compensation

As greater numbers of employers have received the Workers' Compensation Board's approval to self-insure their statutory obligation to provide for workers' compensation benefits, insurance policies providing for reimbursement of such costs above specified self-insured retention limits have become more common. In the past, there have been differences of opinion as to whether such coverages were properly considered and reported as excess general liability insurance, reinsurance, or a form of workers' compensation insurance.

In 1992, the Department was able to arrive at a consensus that the coverage is most appropriately considered a form of workers' compensation insurance. Accordingly, we have begun to process such policies in accordance with the laws and regulations applicable to workers' compensation insurance.

17. Managed Care Initiative

In a major effort to address the spiraling costs of medical care as it relates to State mandated programs, the Department prepared draft legislation to permit insurers and employers to experiment with managed care arrangements in delivering health care to diseased and injured employees covered under the Workers' Compensation Law, and to injured parties covered under motor vehicle no-fault Insurance. The legislation provides for licensing of managed health care networks that will deliver superior care that is professionally monitored to ensure both high quality of service and cost effectiveness.

Managed care networks will be exempt from many of the rules that govern traditional workers' compensation and no-fault medical care delivery systems.

18. Medical Malpractice Insurance

a. Establishment of Rates and Premium Surcharges

Chapter 165 of the Laws of 1991 extended for two years the authority of the Superintendent of Insurance to establish rates for policies providing coverage for physicians and surgeons medical malpractice liability insurance. This legislation also provided that a surcharge of up to 8% annually could be imposed, beginning July 1, 1989, upon the then-established rates if required to satisfy any deficiency for the policy periods July 1, 1985 through June 30, 1989.

Department Regulation 101, as amended, contains the physicians primary medical malpractice insurance occurrence rates, excess medical malpractice insurance rates, premium surcharges, claims-made step factors, and extended reporting period (tail) factors established by the Superintendent each year.

The Regulation also requires insurers to maintain, for each policy year during the period of established rates, segregated accounts for premiums, reserves, and investment income attributable to each policy year, and to annually furnish the Department with reports containing this segregated account information. These reports are due from each insurer on October 1 of each year. The information contained in these reports is used to determine whether deficiencies exist and whether any premium surcharges are necessary.

The Seventeenth Amendment to Regulation 101 was promulgated on July 8, 1992. For most insurers, overall primary medical malpractice insurance rates in New York for the July 1, 1992 through June 30, 1993 policy year remained unchanged from those established the previous year, although certain classification and territorial changes were approved.

In addition, based on a review of the segregated account reports received October 1, 1991, as well as an evaluation of the financial condition of insurers issuing physicians medical malpractice insurance, it was determined that the 4% surcharge imposed since 1989 on Group Council Mutual Insurance Company should continue for the 1992-1993 policy year.

The rates for primary limits of $1 million/$3 million and surcharges that were established for occurrence policies for the period July 1, 1992 through June 30, 1993 for policies issued by the major writers of physicians medical malpractice liability insurance are reflected in Table 39. All other insurers writing physicians medical malpractice liability insurance must use the rates established for the Medical Liability Mutual Insurance Company, unless the insurer can demonstrate to the satisfaction of the Superintendent that another rate is appropriate.

Table 39
PHYSICIANS MALPRACTICE
PRIMARY COVERAGE RATES
July 1, 1992 - June 30, 1993

Insurer	% Change From Previous Year	Surcharge
Frontier Insurance Company	0.0%	0.0%
Group Council Mutual Insurance Company	+5.0	4.0
Medical Liability Mutual Insurance Company	0.0	0.0
Medical Malpractice Insurance Association	0.0	0.0
Physicians Reciprocal Insurers	0.0	0.0

Although the overall rates for the Frontier Insurance Company and Physicians Reciprocal Insurers remained unchanged, simultaneously established territorial and classification revisions resulted in the following selected rate changes:

Frontier Insurance Company

CLASSIFICATION	TERRITORIES[a]		
	01, 02, 03 & 04	05	00
Obstetrics/Gynecology	+8.6	2.4	-14.3
Orthopedic Surgery	+.7	-9.6	-20.5
Neurology (excluding supervision, direction or performance of myelography, angiography and/or pneumoencephalography)	+9.8	-1.4	-13.3
All other classifications	+4.6	-6.1	-17.4

Physicians Reciprocal Insurers

CLASSIFICATION	TERRITORIES[a]			
	02	03 & 05	04	00 & 01
Pediatrics	+13.3	+18.8	+15.5	+10.0
All other classifications	+3.0	+8.0	+5.0	0.0

[a] Territory 01 - New York, Orange, Ulster and Westchester Counties
Territory 02 - Bronx, Kings, Queens, Richmond, Rockland and Sullivan Counties
Territory 03 - Nassau and Suffolk Counties
Territory 04 - Columbia, Dutchess, Greene and Putnam Counties
Territory 05 - Erie and Niagara Counties
Territory 00 - All counties not otherwise listed

b. Application of Premium Surcharges

The premiums of all physicians who were insured with Group Council Mutual Insurance Company any time during the period July 1, 1985 through June 30, 1988 had to be surcharged even if that company no longer insured the physician. The insurer currently providing coverage for these physicians for the policy period beginning July 1, 1992 collected the surcharge and remitted it to Group Council Mutual Insurance Company.

Surcharges were generally not imposed upon physicians currently insured by Group Council Mutual Insurance Company if they were not insured by that insurer during the period July 1, 1985 through June 30, 1988. A surcharge must be collected, however, from any physician insured by Group Council Mutual Insurance Company on or after July 1, 1989 who was not covered by a licensed insurer during the period July 1, 1985 through June 30, 1988. The surcharge collected from these physicians was remitted to insurers in the following proportions:

Medical Liability Mutual Insurance Company	62.05%
Physicians Reciprocal Insurers	23.00
Group Council Mutual Insurance Company	6.10
Frontier Insurance Company	5.65
Medical Malpractice Insurance Association	2.20
Legion Insurance Company	1.00
Total	100.00%

c. Claims-Made Factors and Optional Tail Factors

The claims-made rate is obtained by multiplying the established occurrence rate by the claims-made factor established by the Superintendent. This factor varies depending on the number of years the insured has been covered by the claims-made program. Similarly, the rate for the optional tail coverage that is required to be offered upon termination of coverage is based on the number of years the physician has completed in the claims-made program, and is obtained by multiplying the established occurrence rate by the factor established by the Superintendent.

The claims-made and tail factors for years one through eight were established in previous amendments to Regulation 101. For the Seventeenth Amendment it was determined that no change was needed to these factors. Similarly, factors for years of coverage in excess of eight years were not needed.

The claims-made factors and optional tail factors established by the Superintendent are:

Year in Claims-Made Program	Claims-Made Factors
First	31%
Second	64
Third	85
Fourth	94
Fifth	99
Sixth	102
Seventh	104
Eighth and later	105

Number of Years Completed in Claims-Made Program	Optional Tail Factors
One	74.8%
Two	122.1
Three	146.4
Four	162.4
Five	173.3
Six	181.0
Seven	186.7
Eight or more	190.6

d. Rates for Excess Insurance Coverage

The rates for first and second excess layer insurance coverage established for the policy year July 1, 1992 through June 30, 1993 are the $1 million/$3 million primary rates established for the Medical Malpractice Insurance Association, multiplied by the following factors:

	Purchased by the Physician	Purchased by a Hospital on Behalf of the Physician
First Excess Layer[a]	30.0%	32.2%
Second Excess Layer[b]	22.5	--

[a] First Excess Layer - provides $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage.

[b] Second Excess Layer - provides $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage.

These factors represent a decrease of 10% from the factors established the previous year.

Although the Superintendent is authorized to establish a surcharge on the established rates for excess coverage if required to satisfy any deficiency for the policy period July 1, 1985 through June 30, 1988, it was determined, based on a review of the segregated account reports of those insurers writing the excess coverage, that for the policy year beginning July 1, 1992, no surcharge was necessary.

e. Premium Credits for Physicians Completing Risk Management Programs

Section 2343(e) of the Insurance Law, added by Chapter 642 of the Laws of 1990, provided that the Superintendent may approve an appropriate premium reduction for physicians successfully completing a risk management course, the standards for which would be established by the Superintendent by regulation. Risk management courses focus on improving physician procedures, communication and patient rapport skills, and provide physicians with an overview of the causes of malpractice claims. In theory, there should be a reduction in the frequency and severity of medical malpractice claims as a result of physicians' attendance at these courses.

The Insurance Department surveyed insurers providing malpractice liability insurance, the medical society and entities involved in conducting risk management programs, soliciting comments in such areas as the expected effect of risk management courses on the frequency and severity of losses and expenses, the characteristics of an effective risk management program and the minimum/maximum credit that should be allowed for these courses. The Department also consulted with the New York State Department of Health.

Based upon the comments received, the Superintendent promulgated the First Amendment to Regulation 124. This Amendment established standards for the approval of qualified risk management programs and permitted insurers to file, for approval, a premium credit of up to 5% for physicians who successfully complete such a program.

A qualified risk management program contains two components: a basic risk management course; and a follow-up course to be completed prior to the beginning of the third policy year during which the credit is to be granted.

The basic risk management course must consist of a lecture (or other classroom-setting) component of at least five hours covering topics related to risk management. Within 60 days of attending the lecture component the insured must satisfactorily complete a project designed to demonstrate and reinforce the concepts taught in the lecture.

The follow-up course consists of a lecture (or other classroom-setting) component of at least three hours which, in addition to further reinforcing the concepts covered in the basic course, must bring to the insured's attention any relevant developments since completion of the basic course. Further, unless previously provided in the basic course the follow-up course must contain material specific to the insured's medical specialty.

19. Annual Commercial Property/Casualty Report

Chapter 220 of the Laws of 1986 added Section 334 to the Insurance Law requiring that the Superintendent annually report to the Governor and the Legislature on the status of commercial liability, professional liability, and public entity liability insurance. This Section outlines specific statistical data that are to be included in the report and authorizes the Superintendent to collect that data from insurers.

The fifth Annual Commercial Property/Casualty Report was issued May 1, 1992. Significant findings of this report included:

- In both New York and countrywide, more than four-fifths of the markets showed 1989 ultimate loss ratios that deteriorated from the previous year, although they have not yet reached the levels exhibited before the liability crisis;

- New York's "other liability" market (which includes municipal liability, child care liability, recreational liability, etc.) showed an operating ratio of 111.6% in 1990, a slight improvement from the 113.5% in 1989. This market showed an operating ratio below 100% in 1988, signifying some profitability for the first time since the initial Annual Commercial Property Casualty Report was released. A 100% operating ratio indicates that an insurer is incurring one dollar in losses and expenses for each dollar generated by both premiums and investments;

- For the first time since the crisis year of 1985, the commercial multiple peril market (combined property and liability policies issued to businesses), both in New York and countrywide, registered an operating ratio above 100%, indicating unprofitability in this market.

The 1992 report recommended that the requirement for the Annual Commercial Property Casualty Report be continued since it provides a meaningful method of measuring underwriting results for key liability markets and guidance for future statutory and administrative actions. Given the relatively long-tail characteristics of liability insurance markets, future reports will be even more meaningful.

The report also continued to recommend that the Insurance Department continue to monitor the manual rate levels and rating plans being used by insurers in the liability market. As provided in Regulation 129, insurers must periodically review their rates and make adjustments as necessary. Enforcement of these provisions must continue.

The report also continued to recommended that the Department maintain its vigilance in the area of insurer market conduct. An unequivocal message must be sent to the industry that the public will no longer tolerate widely or wildly swinging rate cycles. The insurance-buying public is ill-served by a system that provides cheap, rock-bottom prices one year and triple-digit price increases the next.

Finally, the report noted that the Insurance Department's ability to impose sanctions upon insures that fail to comply with the statutory data reporting requirements must be strengthened. The current maximum penalty of $500 provides little deterrence for insurers that choose to disregard the filing requirements authorized by Section 334 of the Insurance Law. Legislation should be enacted to provide for cumulative penalties for insurers that repeatedly fail to submit data required for the report, or any other information required by the Superintendent.

20. Excess Line Insurance

Potential insureds who cannot obtain coverage from companies licensed to write insurance in New York may, under circumstances prescribed in the New York Insurance Law and Regulations, obtain such coverage from unlicensed companies through the auspices of a New York-licensed excess line broker.

Inasmuch as the insurers writing this coverage are not licensed by this Department, statistical data relating to the amount and nature of premiums written in the excess line market must be obtained directly from the excess line brokers, through tax statements they are required to file no later than March 15 of each year relating to business written during the previous calendar year. It should be noted that the statistical data used in this annual report pertaining to excess line business were obtained from reports provided to the Superintendent by the Excess Line Association of New York pursuant to Section 2130 of the New York Insurance Law.

For calendar year 1992, total excess line gross premiums written on risks located or resident both in and out of New York State amounted to approximately $706 million of which $402 million was attributable to risks located or resident in New York State only.

a. Business Written in New York

Excess line premiums written in New York State decreased from $433 million in 1991 to $402 million in 1992, a 7.1% decrease. The decrease can be attributed to the softening of the insurance market whereby licensed insurers are writing risks that normally would be written through excess and surplus line brokers.

The largest dollar decline over the year occurred in the errors and omissions line which decreased from $150 million in 1991 to $130 million in 1992, a drop of $20 million. The malpractice line posted the largest percentage decline--61.8%. Other lines that showed decreases over the year were fidelity and surety, down $10 million; fire and allied lines, down $6.5 million; auto physical damage, down $3 million; other lines, down $3 million; and auto liability, down $1 million.

Other liability premiums totaled $138 million in 1992, the largest premium volume of all excess lines written in New York. The 1992 premiums in this line outpaced the 1991 total by $6 million. The largest percentage increase occurred in the burglary and theft line. Although small in volume, this line increased by 75.3%, going from $5 million in 1991 to $9.5 million in 1992. Inland marine and commercial multiple peril increased by $7 and $3 million, respectively.

Table 40
EXCESS LINE PREMIUMS WRITTEN IN NEW YORK STATE
1989-1992
(dollar amounts in thousands)

Line of business	1992	1991	1990	1989
Fire and allied lines	$22,544	$ 29,051	$ 35,027	$ 34,228
Inland marine	36,127	29,480	42,897	29,866
Auto liability	4,394	5,915	5,048	5,106
Malpractice	4,497	11,759	14,883	25,440
Errors and omissions	130,516	150,471	120,563	130,355
Commercial multiple peril (excluding fire)	22,210	19,143	7,259	6,359
Other liability	138,225	131,852	171,766	168,957
Auto physical damage	12,242	15,100	19,872	12,907
Aircraft physical damage	555	380	1,015	490
Burglary and theft	9,527	5,435	11,138	9,438
Fidelity and surety	16,930	27,248	36,143	42,448
Other lines	4,047	6,892	6,069	8,940
Total	$401,814	$432,726	$471,679	$474,534
Excess line premiums as a percentage of all property and casualty insurance premiums written in New York	2.27% (estimated)	2.24%	2.46%	2.58%

Source: Excess Line Association of New York

b. Warranty Programs

The Department has continued its investigation regarding illegal warranty-type insurance products. Last year auto theft warranties were predominant. This year the emphasis was generally on consumer products warranty programs. For a set price these programs offer to repair or replace consumer products if they break during a specified period. For the most part, the Department considers these programs to be insurance and not warranties.

According to current Insurance Law, if the warranty is not incidental to a company's main business activity and is the actual vocation of the company itself, then the company is in fact doing an insurance business. It is the Department's view that Section 1102 of the New York Insurance Law provides that, unless specifically exempted, no entity or person shall do an insurance business in this State unless authorized by a license in force.

Some of these warranty companies have voluntarily ceased doing business in this State and others have gone bankrupt. Still other warranty cases, five in all, have been referred to the Attorney General's office for whatever action they deem appropriate. While most of these companies have not stopped their programs, some of the larger organizations have indicated that they would like to comply with the Insurance Law, although they do not concede that their programs should be classified as insurance.

Legislation is pending that may alter the Department's treatment of the warranty business. Until that time, the Department will investigate all programs brought to its attention that may be violative of the law.

c. Proposed Regulation 41

In August 1991, the Department released to the Legislature and the industry copies of the proposed redraft of Insurance Department Regulation 41 (NYCRR27) dealing with excess line placements.

The proposed redraft of the regulation contains revisions that represent clarification and modernization from the current 1980 regulation. Some of the highlights of the changes involve the increase in the trust fund requirements and the capital and surplus requirements for alien and foreign insurers doing business in New York State; clarification of the duties and responsibilities of the licensed excess line brokers and the Excess Line Association of New York; the application of minimum policy provisions to the excess line market; and the clarification of the use of residual markets before accessing the excess line market.

The Department held ongoing meetings with representatives of excess line brokers from September 1991 to November 1992 on the regulation. Several suggestions from the industry would require legislative action. The Department adopted some of the suggested changes but resisted any changes that are contrary to the statute and the intent of the legislature.

On February 19, 1993 the proposed regulation was sent to the State Register.

d. Liability Risk Retention Act of 1986 - Purchasing Groups

Purchasing groups are allowed, pursuant to the federal Liability Risk Retention Act of 1986, to buy commercial liability insurance on behalf of members on a group basis. These groups are exempt from any state insurance laws that hinder or prohibit group self-insurance programs and the purchase of liability insurance on a group basis.

As of December 31, 1992, the Department had received notices of intent from 385 purchasing groups. Subsequently, 182 have withdrawn their notice of intent, 27 have notified the Department of their inactive status and 28 have been given ineligible status by the Department due to failure to comply with all the requirements of the applicable laws and regulations. Of the remaining 148 purchasing groups, 39% have named unlicensed companies as their intended insurers.

Some of the most common types of businesses and professions that have formed these purchasing groups include environmental impairment operators, health care facilities and sports and recreation entities.

21. Market Conduct Investigations

a. Market Conduct Fines Collected

The Market Conduct Unit continued its program of reviewing insurance underwriting, rating and claims practices to determine compliance with the Insurance Law and Department regulations.

Twenty-five market conduct investigations were initiated during 1992 bringing to 65 the total number of investigations in progress as of the end of the year. In addition, one statutory rate service examination was in progress and one statutory rate service examination report was filed during the year. Twenty stipulations were entered into during the year. The fines collected as a result of admitted violations totaled $1,357,954. Last year the amount collected was $854,550 plus a Court of Appeals decision which resulted in a fine of $425,000.

Signed Stipulation By:	Amount
Allianz Insurance Company	$81,000
Amerisure Group	
Amerisure Insurance Company	57,028
Michigan Mutual Insurance Company	31,884
Countrywide Insurance Company	91,112
Crum & Forster Group	
Westchester Fire Insurance Company	59,700
North River Insurance Company	79,600
United States Fire Insurance Company	75,000
International Insurance Company	10,800
Fireman's Fund Group	
American Insurance Company	170,091
Fireman's Fund Insurance Company	32,086
National Surety Insurance Company	127,998
American Automobile Insurance Company	64,825
Frontier Insurance Company	50,000
Galaxy Insurance Company	12,000
Greater N.Y. Mutual Insurance Company & Insurance Company of Greater New York	25,400
Home Mutual of Binghamton	34,209
Interboro Mutual Insurance Company	77,150
National Union Fire Insurance Company	200,000
New York Central Mutual Fire Insurance Company	51,121
Tower Insurance Company	26,950
Total	$1,357,954

b. Penalties Imposed Under Section 3425 - New York Insurance Law (NYIL)

Section 3425 - NYIL limits the total number of nonrenewals of personal automobile insurance policies that an insurer is allowed. Generally an insurer is permitted to nonrenew up to 2% of the total number of covered policies that the insurer had in force at the previous year-end in each such insurer's rating territory in use in this State. As a result of an analysis of reports to the Superintendent required by Section 3425(l)(1) - NYIL, the following fines were collected during calendar year 1992:

For Calendar Year 1990	Amount
Aetna Casualty & Surety Company	$1,900
Amerisure Insurance Company	3,700
Automobile Insurance Company of Hartford	5,300
Covenant Insurance Company	800
Excelsior Insurance Company	2,200
Hartford Fire Insurance Company	1,900
National Grange Mutual Insurance Company	4,000
Phoenix Mutual Insurance Company	5,000
Royal Insurance Company	2,400
Safeguard Insurance Company	600
Travelers Insurance Company	2,000
Utica Mutual Insurance Company	7,100
Total	$36,900

c. Penalties Imposed for Late Filings of Form 131-A

Regulation 131 was promulgated on July 13, 1987 setting forth data-reporting requirements for commercial property/casualty insurers. Regulation 131 implements Section 334 of the Insurance Law which is the reporting or sunshine component of omnibus legislation enacted by Chapter 220 of the Laws of 1986 in response to the liability insurance availability and affordability crisis. The Superintendent submits every May 1 an Annual Commercial Property/Casualty Insurance Report to the Governor and the Legislature, based upon data received from insurers concerning commercial risk, public entity and professional liability insurance costs, experience and profitability.

Section 162.4(a) of Regulation 131 requires all insurers to complete Form 131-A for New York experience, setting forth direct written premiums for selected markets for each calendar year. These forms had to be completed by insurers for calendar year 1991 and submitted to the Department no later than April 15, 1992. Based on an analysis of these forms some insurers would be required to submit further statistical data.

A review of insurers' compliance with Regulation 131 disclosed that many insurers had not submitted Form 131-A to the Department by the required date. As a result of this review these companies were informed that a penalty was being imposed for a late filing of Form 131-A. Previously, insurers who had not submitted Form 131-A by the required date paid penalties based upon the number of calendar days the required form was late.

In a November 29, 1990 decision, the Court of Appeals ruled that failure to file Form 131-A constitutes one offense regardless of the number of days the required form was late. The maximum penalty permitted by Insurance Law is $500 for each offense.

During calendar year 1992, 16 insurers paid a total of $8,000 in penalties for late filings of Form 131-A. This represents a $500 penalty for late filing for each company not in compliance with the Regulation.

As a result of the Court of Appeals decision, the Department has proposed legislation to amend the Insurance Law by adding a new subsection (c) to Section 308, to provide for a penalty of up to $250 for each day of delay in submitting a required special report to the Superintendent. The penalty would be subject to a maximum of $25,000.

d. Overcharges Remitted to Policyholders

As a result of the terms agreed to in a stipulated settlement of a market conduct investigation of underwriting and rating practices of commercial risks, the Jefferson Insurance Company was required to perform re-rating reviews for the period November 1, 1989-October 31, 1990. A total of $71,658 in premium overcharges was refunded as a result of this review.

e. Reports on Examination of Rate Service Organizations

The statutory Report on Examination of Automobile Insurance Plans Service Office (AIPSO), a rate service organization, was filed on December 2, 1992.

22. Motor Vehicle Law Enforcement Fee

Section 386 of Chapter 55 of the Laws of 1992 amended the Insurance Law by adding new Section 9110, entitled Motor Vehicle Law Enforcement Fee.

This new section now requires every insurance company authorized to do business in this State to charge and collect an annual Motor Vehicle Law Enforcement Fee from each holder of a policy issued or renewed with an effective date on or after July 1, 1992 in this State, or for delivery in this State, for motor vehicle liability insurance coverage.

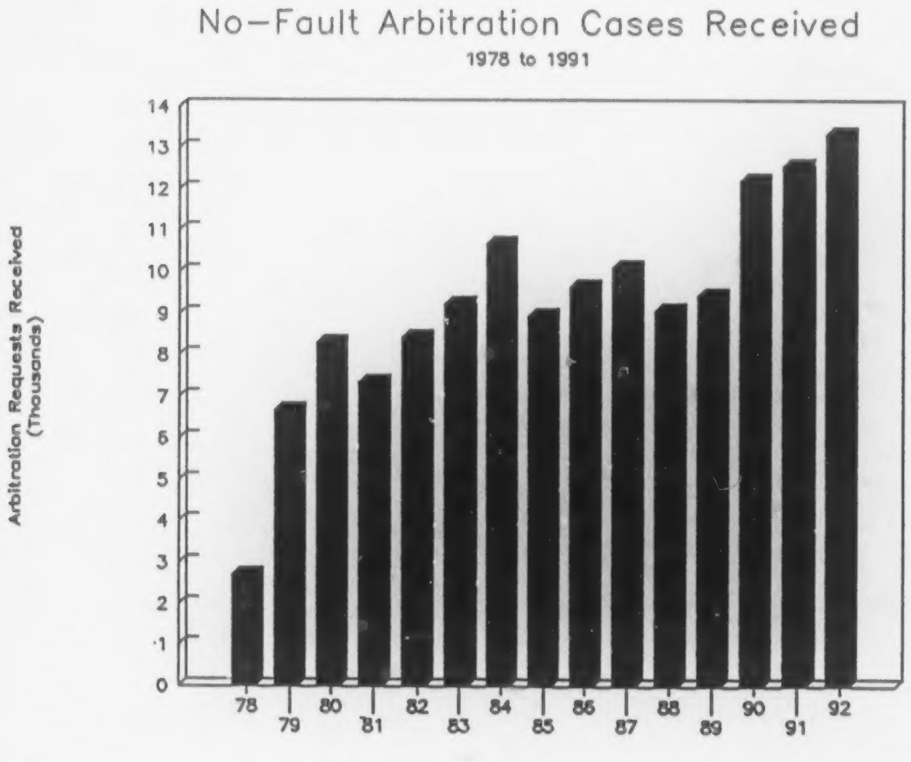
Motor vehicles not subject to the law include ambulances; motor vehicles owned or controlled by governmental entities; auto trucks and light delivery cars; tractors; buses; taxicabs and liveries; hearses; historical motor vehicles; trailers; semi-trailers; coach or house trailers; and certain other motor vehicles as described in subdivision 6 of Section 401 of the Vehicle and Traffic Law.

23. Automobile Insurance

a. No-Fault Motor Vehicle Insurance Law Activity - 1992

Insurance Department Administration of the Optional Arbitration System:

Effective with disputes arising out of accidents occurring on and after December 1, 1977, the Department administers the arbitration of no-fault disputes involving the payment of first-party benefits to claimants. The volume of requests for arbitration began to increase in 1990 when the number of requests rose 29%, up from 9,457 to 12,233. In 1991 such requests increased by 3% to 12,580, and in 1992 by 6% to 13,371.



The Department continues to be successful in its role as a conciliator of no-fault disputes. Of the disputes received in 1992, Department examiners conciliated 3,999: The Department's success rate of 37.2% represents an increase from the 36.6% experienced in 1991.

The promulgation of the Twentieth Amendment to Regulation 68, effective July 1,1988, changed the structure of the No-Fault Arbitration System in order to establish a more equitable and efficient system for the adjudication of no-fault disputes. The Amendment reduced the number of arbitration forums from four to two by eliminating the Expedited Arbitration forum administered by the American Arbitration Association (AAA) and the Health Service Arbitration forum administered by the Workers' Compensation Board. Insurance Department Arbitration (IDA) resolves disputes involving the correct computation of health service provider fees, amounts in dispute under $400, and disputes solely involving interest and attorneys' fees. All other disputes fall under the jurisdiction of the American Arbitration Association. The arbitrators employed under the new system devote a major portion of their time to adjudicating no-fault disputes, resulting in more consistent application of the No-Fault Law and implementation of regulations.

The IDA's expanded role under the Twentieth Amendment has resulted in the adjudication of 1,308 cases in 1992, an increase from the 1,091 cases decided in 1991. This accounted for 12.2% of all cases referred to arbitration in 1992. Accordingly, 49.3% of all no-fault cases closed in 1992 were resolved either through conciliation by the Insurance Department or by the Department's IDA forum.

The Department's direct involvement in the arbitration process contributes to the consistent application of the No-Fault Law as well as substantial savings in arbitration administrative expenses and legal fees paid by no-fault insurers.

Table 41
DISPOSITION OF NO-FAULT ARBITRATION CASES
1990-1992

	1992		1991		1990	
	No. of Cases	Percent of Closed Cases	No. of Cases	Percent of Closed Cases	No. of Cases	Percent of Closed Cases
Total Cases Received by the Department	13,371		12,588		12,233	
Disposition: Disputes Conciliated by the Department	3,999	37.2%	3,798	36.6%	3,644	35.7%
Transmitted for Arbitration to: American Arbitration Forum (AAA)	5,454	50.6	5,484	52.9	5,506	53.9
Insurance Department Arbitration Forum (IDA)	1,308	12.2	1,091	10.5	1,062	10.4
IDA and AAA Concurrently	2	a	3	a	6	a
Total Transmitted for Arbitration	6,764	62.8	6,578	63.4	6,574	64.3
Total Closed	10,763	100.0	10,376	100.0	10,218	100.0
Pending Disposition	2,608		2,212		2,015	

[a] Less than 0.1 percent

Table 42
SOURCES OF APPLICATIONS FOR NO-FAULT ARBITRATION
1990-1992

	1992		1991		1990	
	No. of Disposition Cases	Percent of Total	No. of Disposition Cases	Percent of Total	No. of Disposition Cases	Percent of Total
Applications Made by Assignees	8,296	62.0%	8,018	63.7%	7,931	64.8%
Applications Made by Claimants	5,075	38.0	4,570	36.3	4,302	35.2
Total	13,371	100.0%	12,588	100.0%	12,233	100.0%

b. No-Fault Law Changes

Chapter 320 of the Laws of 1991 amended New York's No-Fault Law resulting in two changes. The first change increases the loss of earnings benefit to a maximum of $2,000 a month from $1,000 a month. The second change was the creation of an Optional Basic Economic Loss (OBEL) coverage. This option differs from the additional no-fault coverage that has been available in that this new coverage, if purchased, will allow policyholders an additional $25,000 of basic economic loss coverage which can be designated by an eligible injured person to be applied specifically to loss of earnings from work and/or psychiatric, physical or occupational therapy and rehabilitation. This legislation required the Department to promulgate rules modifying the mandatory and optional no-fault coverages and establishing new claims-handling procedures.

The legislation took effect 120 days after it became law. Therefore insurers were required to offer the OBEL coverage to all new and renewal policyholders with policies effective on or after November 12, 1991. Since the new law was worded to take effect 120 days after enactment, the Department concluded that the loss of earnings increase would apply to all loss of earnings incurred on and after that date, regardless of the date of the accident or the terms of the insurance policy. This interpretation reflected the provisions of the legislation and was most consistent with prior amendments to the No-Fault Law and the Workers' Compensation Law and recognized that no-fault coverage is a part of a complex automobile insurance reparations system.

The Department's implementation of the legislation by means of the Twenty-Second Amendment to Regulation 68 was followed by a lawsuit by an insurer trade association and several individual insurers challenging the constitutionality of the new law, charging that it impaired existing contracts. On January 10, 1992 in State Supreme Court, Albany County (Index No. 6972-91), Justice Harris issued a Preliminary Injunction that enjoined the Superintendent from implementing Chapter 320, insofar as it purported to increase the maximum mandatory benefit payable for loss of earnings from work under policies entered into prior to November 12, 1991. The Preliminary Injunction did not apply to wage-loss claims arising out of accidents covered under policies issued or renewed on and after November 12, 1991.

On July 17, 1992, Chapter 320 of the Laws of 1991 was amended by Chapter 484 of the Laws of 1992 to clarify the effective date of the increased loss of earnings benefit. Chapter 484 of the Laws of 1992 provided that the effective date for the increased benefit would be applicable to accidents arising out of the use and operation of motor vehicles on and after November 12, 1991. The increased loss of earnings benefit does not apply to accidents that occurred prior to November 12, 1991. All motor vehicle policies in force on and after November 12, 1991 are construed to provide the increased loss of earnings benefit. Payments of the increased benefit for loss of earnings from work made by an insurer on those policies issued or renewed prior to November 12, 1991, would be deemed to have been made timely if made by November 14, 1992.

Chapter 484 of the Laws of 1992 also provided that insurers could request an appropriate rate adjustment for basic economic loss coverage for policies issued or renewed in the future, reflecting unanticipated loss experience resulting from the increase in first-party benefits for loss of earnings from work effected by Chapter 320 of the Laws of 1991.

c. Supplementary Uninsured Motorists Endorsement

In July, the Department promulgated Regulation 35-D which required insurers to offer, with all new and renewal policies becoming effective on and after October 1, 1992, a prescribed Supplementary Uninsured Motorists (SUM) endorsement to enable policyholders to recover damages resulting from accidents involving other motor vehicles that are uninsured or, even if insured, are insured for third-party bodily injury (BI) at relatively low liability limits. For example, a driver with $100,000 of BI liability coverage would be protected against lawsuits up to that $100,000 limit. However, that same driver's ability to recover damages would be severely limited if he were to sustain serious injuries as a result of an accident with someone who had only $10,000 of BI coverage. If the first driver had purchased SUM coverage up to his BI limits, he could recover up to $100,000 in damages in total.

The Regulation is considered necessary to address the problems created by the marketing of varying supplementary uninsured motorists endorsements by insurers. Insurers, in developing their own individual SUM endorsements, have attempted to interpret Section 3420(f)(2) of the Insurance Law, the legislation that requires them to offer SUM coverage, and have also attempted to reflect various court decisions that have interpreted both the law and the individual endorsements. The prescribed endorsement should reduce much of the confusion regarding SUM coverage, make it easier to collect benefits recoverable under the coverage and, when disputes arise, make it simpler to resolve those disputes.

The most controversial aspect of supplementary uninsured motorists coverage has been the application of an offset for amounts recovered from tortfeasors. Much of the litigation involving the coverage has addressed this issue. The issue has also been addressed by the Court of Appeals. A review of the legislative history indicates the Legislature intended for SUM coverage to allow an insured to collect, from that person's own insurer and any other motor vehicle liability insurer, an amount at most equivalent to the amount of bodily injury liability insurance coverage that the insured had purchased. The "Summary of Provisions of the Bill" in the bill memorandum states in part that "...by purchasing this option, the insured would obtain the same level of protection for himself and his passengers which he purchased to protect himself against liability to others." Court decisions expressed concern that the full amount of SUM coverage would never be paid because of the existence of minimum liability insurance requirements in New York State. The Court of Appeals in United Community v. Mucatel, 513 N.Y.S.2nd 114, 69 N.Y.2d 777 (1987), awarded the full amount of the supplementary uninsured motorists coverage without the application of the offset specified in the policy. In this case, the Court determined that the dollar amount of the coverage that was stated on the declarations page was rendered ambiguous by the offset and any such ambiguity had to be construed in the insured's favor.

The ambiguity problem is being addressed in this Regulation by incorporating the uninsured motorists coverage into the supplementary uninsured motorists coverage and by stating, both within the endorsement and on the declarations page, that the maximum payment under the SUM coverage will never be more than the difference between the amount of SUM coverage available to the insured and the total bodily injury liability coverage recoverable by such insured from those that may be held legally liable for the bodily injury because of the use or operation of a motor vehicle. Utilizing this approach, the full amount of SUM coverage would be paid only when the insured is the victim of an uninsured motorist. This approach represents a less expensive approach than one that would not permit an offset. Savings associated with the adoption of this approach will make the coverage more affordable, resulting in more widespread purchase of the coverage.

The Department's authority to promulgate the Regulation was challenged by the National Association of Independent Insurers, Government Employees Insurance Company, United Services Automobile Association and State Farm Insurance Company. The petitioners challenged the offset and the non-stacking provisions that are contained in the Regulation and were granted a stay that prohibits the Department from enforcing the Regulation. The Department's authority to promulgate the Regulation was upheld by New York State Supreme Court and, upon appeal, unanimously by the Appellate Division, First Department. The petitioners have indicated that they will request leave to appeal to the New York State Court of Appeals. If the Department prevails, it will amend the effective date of the Regulation after all appeals have been exhausted.

d. Availability of Automobile Insurance

On July 22, 1992 the New York City Department of Consumer Affairs (CAD) issued its report entitled "The Poor Pay More...For Less - Part 2: Automobile Liability Insurance." The report raises several questions regarding the fact that good drivers living in "lower income" areas can only obtain their auto insurance from the New York Automobile Insurance Plan (Assigned Risk Plan).

The plan provides auto insurance to New York drivers who cannot obtain coverage through the voluntary insurance market. The report indicated that some drivers pay up to three times more than drivers in the voluntary market not because of their driving records but because of their residence.

The Insurance Department cooperated with CAD staff, supplying records and technical expertise during the year-long study. The report is critical of the Assigned Risk Plan, insurers and producers. It briefly acknowledges the Department's contribution to the report but also criticizes the Department's action or lack of action in addressing the issues raised in the report. Little or no credit is given in the report to the Department for recognizing the problems several years ago and implementing several innovative long-term initiatives designed to encourage depopulation of the Assigned Risk Plan.

On September 9, 1992, the Department testified at a public hearing before Senator Guy J. Velella and the New York Senate Committee on Insurance. Primarily, the hearing sought to examine the allegations made by Commissioner Mark Green of CAD.

In his opening remarks, Senator Velella appeared to accept at face value the general premise of the CAD report, namely that unfair discrimination in both accessibility and pricing of automobile insurance predominately in New York City does exist. In fact, the Senator implied that the actual purpose of the hearing was to determine whether new legislation was needed or whether current legislation was adequate but just not being efficiently enforced.

The Department's testimony acknowledged the fact that many of the insureds comprising the 17% assigned risk population in New York do not belong in the plan. In recognition of this fact, the testimony discussed a number of innovative coordinated programs both formulated and implemented by the Department designed to depopulate the plan over a phase-in period, e.g., the Territorial Credit Program (TCP) and the Take Out Program (TOP). While definitive conclusions about the efficacy of these programs are premature, signs of progress are becoming visible. Other actions being contemplated by the Department for furthering its goal of depopulation were also discussed.

The Department's testimony also addressed specific conclusions and recommendations in the CAD report characterizing them as "without warrant or merit."

In addition to Mark Green and the Department, testimony was given by various other industry representatives the majority of which agreed with the Department's position.

e. Territorial Credit Program

On January 27, 1993, a directive was issued by the Superintendent to the New York Automobile Insurance Plan refining the Territorial Credit Program that was originally instituted by the Department on August 15, 1989. The modifications to the program call for adjustments to the quota allocations for 1993 and after to allow credits in the designated territories to be determined in those ZIP Code areas within such territory with a higher proportion of assigned risks than that territory bears as a whole.

The directive is designed to strengthen a Department initiative to reduce the number of drivers in the New York Automobile Insurance Plan. The territorial credit system by ZIP Code enables auto insurance companies to write more business in the voluntary market especially in places with proportionally higher residual market share, particularly the New York City metropolitan area. The credit system allows insurers to reduce their future Plan assignments by voluntarily covering motorists in areas where the percentage of drivers in the Plan exceeds the state-wide average.

f. Section 3425 Report to the Legislature

On March 15, 1992, the Department issued a comprehensive report to the New York State Legislature pursuant to Section 3425 of the Insurance Law. In the report, the Department urged that Section 3425 be continued for at least five years. Section 3425 was extended four more years to August 1, 1996. It continues to be the Department's view that a permanent or long-term extension of Section 3425 would best serve the interests of the insurance-buying consumer as well as the insurance industry by enhancing market stability on a long-term basis.

g. Automobile Physical Damage

Circular Letter No. 9 dated June 5, 1992 advised insurers writing motor vehicle physical damage insurance, including producer and claim adjuster organizations, of the requirements of Section 2610 of the Insurance Law. This Section prohibits insurers from requiring any consumer to use a particular place or specific shop for necessary automobile repairs or replacement including window glass. However, an insurer may refer consumers to specific shops if a claim involves only window glass.

h. Notices Sent of Legislative and Other Changes Affecting Automobile Insurance

On December 11, 1992, the Department issued Circular Letter No. 11 informing auto insurers of the impact of several recent pieces of legislation on automobile insurance policies. The changes are intended to increase consumer protection and understanding. The Circular Letter summarized the changes to Regulation 68, Section 2345-NYIL, 9110-NYIL, and Regulation 35-D as they impacted consumers. These requirements include: the disclosure of no-fault coverages, limits and premiums; the disclosure of dollar amount of premium discounts and surcharges; disclosure of the $1.00 Motor Vehicle Law Enforcement Fee, and the disclosure that may be required for uninsured and supplementary uninsured motorists coverages under Regulation 35-D. (The enforcement of Regulation 35-D has been temporarily stayed by court action.)

On December 29, 1992, two circular letters were published by the Department:

> Circular Letter No. 7 provided the updated list of sponsors that are currently approved by the Department of Motor Vehicles to administer the Motor Vehicle Liability and Collision Insurance/Point Reduction Program courses. The passing of one of these courses entitles automobile insurance policyholders to receive a 10% discount on most automobile insurance coverages, and to remove up to four accumulated points from their drivers' licenses.

Circular Letter No. 8 provided insurers with a statement setting forth the penalties for conviction(s) of driving while under the influence of alcohol or drugs. The most recent relevant changes became effective for all violations on or after November 1, 1992. The Vehicle and Traffic Law requires the Insurance Department to prepare this statement in consultation with the Department of Motor Vehicles and to supply it to insurers for dissemination to policyholders.

i. Consumer Guide for Automobile Insurance

Chapter 647 of the Laws of 1992 added new Sections 337 and 338 to the Insurance Law which impose the following requirements on the Department:

By October 1 of each year and beginning in 1993 the following consumer information on private passenger automobile insurance will be required to be published and distributed:

a. an annual ranking of private passenger automobile insurers based on each insurer's consumer complaint record;

b. a list of models of cars for which consumers can expect to pay higher premiums;

c. an explanation of required and optional automobile coverages;

d. recommendations as to how to shop for, and compare prices, service and quality of, automobile insurance coverage;

e. cost and availability information by territory for various classes of drivers; and

f. an explanation of prohibited discriminatory practices applying to insurance companies, agents and brokers

In addition, as required by the statute, a Department toll-free consumer hotline has been established so that consumers may initiate complaints and request general information about automobile insurance.

When published, all of the above information will be made available at every Department of Motor Vehicle office and public library in the State.

In addition, every two years beginning no later than May 1, 1994 the Superintendent must furnish to the Governor and the Legislature a report concerning the New York Automobile Insurance Plan including the following:

a. the number, experience, class, age, sex and geographical location of drivers in the Plan by rating territory and postal ZIP Code;

b. a summary assessment of insurer nonrenewals and cancellations based on geographical location of the risk or producers incorporating information on age and sex;

c. a summary assessment of Department efforts in maintaining or reducing the population of the Plan; and

d. any recommendations for further statutory or administrative action designed to reduce the Plan's population.

24. Homeowners Insurance

In the wake of Hurricane Andrew which occurred in August and the Nor'easter of December 11, 1992, Long Island coastal areas have been targeted by insurers as areas with the highest probability for future severe storm damage.

In light of these predictions several companies have informed the Department that they will cease or limit their writings in the Long Island area. Several companies indicated they will not renew policies within a certain distance of the coastline. The Department is taking various steps to monitor the availability of insurance in this market. Subsequent to the storm of December 11, the Department conducted a preliminary telephone survey of the top 22 carriers in the homeowners insurance market accounting for about 78% of the market, to determine the effects of the storm on their loss experience and future underwriting. The information requested included: amount of written premiums in these areas, dollar amount of the storm losses, and any underwriting policy changes they may intend to make as a result of the storm. A formal written request for information will be conducted as a follow-up. Approximately 20% of the carriers indicated an intent to cease or reduce writing new business in these flood-prone areas.

25. Rate Adjustments of Individual Policyholders

Certain complaints and inquiries are handled independent of the Consumer Services Bureau and primarily involve requests from insureds or their brokers for information generally concerning rates charged for personal auto and dwelling insurance, as well as premiums charged for commercial risks.

A total of 3,233 such complaints and inquiries were received in 1992. This total consisted of 2,246 involving personal automobile, 133 involving commercial automobile, 98 involving homeowners, 121 involving medical malpractice, 62 involving title insurance, and 573 involving all other types of insurance (surety, inland marine and other liability, etc.). A total of 757 personal and commercial automobile rating complaints were closed during the year, in which 145 policyholders were found to have been overcharged. These investigations resulted in premium refunds of $89,696.

Not included in the foregoing was a unique situation involving a commercial auto policy that resulted in a return premium of $321,140 to an insured who leases trucks.

Casualty Actuarial Bureau

The Casualty Actuarial Bureau reviews rate filings for private passenger automobile and workers' compensation Insurance. All such filings must receive the prior approval of the Superintendent before they take effect. These coverages are the largest (in terms of premium volume) of the property/casualty coverages, accounting for roughly $10 billion of premium writings in 1992.

1. Private Passenger Automobile Insurance

Automobile insurance is vital to New Yorkers; drivers cannot register their cars unless they purchase automobile insurance. Most insurers' rate submissions are technically complex documents and are given to the Department's casualty actuaries for analysis.

In 1992, the Department approved 55 requests for changes in private passenger automobile rates. Most approved rate increases reflected some reduction from the requested changes. Table 43 lists both requested and approved rate changes, along with the liability and physical damage components of the approved changes.

The average rate change for insurers who received rate changes in 1992 was approximately 5.6%. The 55 insurers who changed their rates represent 70% of the total market for private passenger automobile insurance. Rates for the liability portions of the policy increased an average of 12.7% while the physical damage coverages decreased by 5.7%. The average requested rate change was 8.5%.

The Insurance Services Office (ISO), a rate service organization and statistical agent, has submitted a preliminary loss cost filing to the Department. Under the proposed method ISO would file only pure premiums, the portion of the premium dollar that pays for losses, for its member companies. These pure premiums would be modified to reflect loss development and trend, to represent the ultimate payout on losses for the proposed effective period. It would then be the responsibility of the individual member company to add in its own expense elements to produce its new rates. These new rates will be the individual company equivalents of the filed rates in the traditional ISO advisory filings. The change to loss costs is being made (at ISO's initiative) in order to promote competition and price determination at the individual-company level. In New York, however, only the smallest insurers fashion their rates after those filed by ISO. Larger insurers, even those that are members of or subscribers to ISO, have traditionally made independent filings based on their own data.

In addition, statutory changes made in 1992 will require discounts for comprehensive insurance to be offered for several anti-theft devices, including window etching and homing devices.

Table 43

PRIVATE PASSENGER AUTOMOBILE RATE CHANGES APPROVED IN 1992[1]

Renewal Effective Date	Insurer	Market Share (%)	Requested % Change	Approved % Change[2]		
				Liability	Physical Damage	Total
11/7/92	Allstate Ins. Co.	17.59	0.3	8.6	-10.1	0.3
10/15/92	AIPSO	15.28	10.8	11.9	-2.7	9.0
6/26/92	Aetna Group	5.89	17.7	15.4	-3.2	7.0
9/15/92	GEICO; GEICO General	4.43	6.9	17.5	-10.1	5.0
11/26/92	Liberty Mutual Fire; Liberty Ins. Corp.	2.96	5.6	11.1	-2.0	5.1
10/1/92	Nationwide Mutual Ins. Co.	2.94	3.4	7.9	-6.6	1.9
7/1/92	New York Central Mutual Ins. Co.	2.04	7.2	11.8	0.0	7.2
3/1/93	CNA Group	1.83	15.8	24.1	-9.4	10.8
2/1/93	Metropolitan Group	1.72	11.3	10.8	5.8	9.1
11/25/92	USAA; USAA Casualty Ins. Co.	1.48	7.0	20.4	-13.6	2.5
11/23/92	Commercial Union Group	1.21	8.8	19.8	-7.0	8.4
4/22/92	Hanover; Mass. Bay Ins. Co.	1.20	22.8	21.4	5.9	15.4
1/1/93	Amica Mutual Ins. Co.	1.19	3.1	10.3	-6.6	3.1
3/3/93	Prudential Group	1.15	8.2	14.0	-10.3	4.7
6/1/92	Empire Ins. Co.; Allcity Ins. Co.	1.04	12.5	19.2	2.3	12.7
5/15/92	Chubb Group	1.04	11.1	2.2	0.0	0.9
10/15/92	Progressive Casualty Ins. Co.	0.94	6.2	10.0	0.0	6.2
8/23/92	Colonial Penn Group	0.76	20.4	25.0	0.3	14.6
2/1/93	CIGNA Group	0.64	16.6	18.9	-10.3	7.4
5/1/92	Worldwide Group	0.39	6.9	14.7	-2.2	6.9
1/1/93	Interboro Mutual Indemnity Ins. Co.	0.34	11.6	19.1	0.1	10.2
10/16/92	United Community Ins. Co.	0.32	35.3	17.3	-0.7	9.7
5/19/92	Fireman's Fund Group	0.28	9.0	11.1	2.4	7.3
11/4/92	Bankers & Shippers Ins. Co.	0.27	5.3	14.0	-3.1	5.3
11/1/92	State-Wide Ins. Co.	0.24	20.9	19.6	0.0	11.7
11/1/92	Peerless Ins. Co.; Excelsior Ins. Co.	0.21	5.9	12.6	-4.8	5.9
11/15/92	Crum & Forster Group	0.20	38.0	17.5	0.0	8.1
10/1/92	Preferred Mutual Ins. Co.	0.18	6.1	12.0	-2.0	6.1
4/1/92	New York Casualty	0.17	7.3	26.0	-15.0	7.3
4/20,11/23	Allstate Indemnity	0.17	0.0	32.4	-1.7	-1.7
3/4/92	Great American; Agricultural Ins. Co.	0.16	26.1	24.5	-1.2	11.4
8/1/92	Tri-State Consumer Ins. Co.	0.15	9.0	10.4	0.0	6.5
8/15/92	Transamerica Group	0.15	9.2	14.1	3.5	9.2
12/15/92	Assurance Co. of America	0.13	-2.0	-0.6	-3.4	-2.0
8/1/92	Worcester Insurance Company	0.13	7.9	29.5	-16.7	5.9

Renewal Effective Date	Insurer	Market Share (%)	Requested % Change	Approved % Change[2]		
				Liability	Physical Damage	Total
10/15/92	**Progressive Specialty**	**0.13**	**-1.5**	**0.0**	**-2.7**	**-1.5**
4/1/92	**Eveready Ins. Co.**	**0.11**	**15.5**	**24.1**	**-4.2**	**15.5**
2/1/93	**Exchange Ins. Co.**	**0.10**	**19.0**	**19.0**	**19.0**	**19.0**
3/1/93	**New Hampshire Ins. Co.**	**0.10**	**44.8**	**25.0**	**0.0**	**13.0**
4/6/92	**GEICO Indemnity**	**0.08**	**13.2**	**20.6**	**4.8**	**13.2**
10/30/92	American Economy; American States	0.07	9.6	13.2	-0.6	8.0
11/23/92	U.S. Capital Ins. Co.	0.07	19.0	13.2	25.3	19.0
7/1/92	Paramount Insurance Company	0.07	35.8	36.8	35.0	35.8
10/1/92	AIU Ins. Co.; Illinois National Ins. Co.	0.04	19.5	25.0	4.7	13.4
10/1/92	MCA Insurance Company	0.03	16.9	19.7	12.9	16.9
12/15/92	**Eagle Insurance Co.**	**0.02**	**11.8**	**15.9**	**-2.2**	**11.8**
11/15/92	**Windsor Insurance Co.**	**0.02**	**6.8**	**15.4**	**-2.9**	**6.8**
11/24/92	**American National Fire**	**0.01**	**-5.4**	**0.0**	**-10.2**	**-5.3**
1/1/93	**Sterling Ins. Co.**	**0.01**	**6.6**	**11.9**	**-0.3**	**6.5**
2/1/93	**Capital Mutual Ins. Co.**	**0.01**	**4.2**	**15.2**	**-9.8**	**4.2**
7/3/92	Amex Assurance Company	0.00	5.1	12.6	-2.2	5.1
7/1/92	National Continental Ins. Co. (new)	0.00	0.0	0.0	0.0	0.0
5/1/92	Capital Enterprise Ins. Co. (new)	0.00	6.1	0.0	0.0	0.0
10/1/92	American International Ins. Co. (new)	0.00	0.0	0.0	0.0	0.0
1/1/93	Amer. Home Assur.;Nat. Union Fire (new)	0.00	0.0	0.0	0.0	0.0

Average liability change for insurers receiving rate changes · · · ·	12.68%
Average physical damage change for insurers receiving rate changes	-5.65%
Average change for insurers receiving rate changes · · · · · · · · ·	5.60%
Total written premium of the above listed insurers (000's) · · · ·	$4,527,212
Percentage of total industry premium affected (cumulative market share)	69.70%
Overall effect on the total industry premium from above changes · ·	3.90%

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[1] Rates are based upon 1992 approved rates. Insurers' "use and file" downward deviations based upon §2328 of the New York State Insurance Law have not been included.

[2] All rate changes are calculated using premiums obtained from 1990 Annual Statement data.

2. New York Automobile Insurance Plan

Private passenger automobiles insured through the Automobile Insurance Plan (Assigned Risk Plan) received a 9.5% rate increase effective September 1, 1992 for new business and October 15, 1992 for renewals. The Plan covers individuals who cannot obtain insurance in the voluntary market. These individuals are often referred to as assigned risks.

a. Plan Experience in 1991 and 1992

(i) Number of Policies Written

Net policies written through the Assigned Risk Plan decreased by 7.2%, going from 1,430,462 in 1991 to 1,327,128 in 1992. Table 44 shows policies by coverage and issuance category for 1991 and 1992. The data include single and nulti-car risks for both private passenger and commercial policies.

(ii) Earned Car Years

An important indicator of the size of the Assigned Risk Plan is earned car years. An earned car year is one car insured for one year. Table 45 shows a ten-year history for voluntary liability coverage and for assigned risk liability and physical damage coverage. During 1990, 17.0% of all New York State private passenger automobiles were assigned risks; this percentage fell to 16.7% in 1991. In addition, the actual number of private passenger automobiles insured through the Plan decreased for both liability and physical damage. This marks the first time in this ten-year period that assigned risk liability earned car years decreased from the previous year and the fourth time for physical damage. The Insurance Department has implemented several initiatives designed to depopulate the AIP, and while it is too soon to measure the effectiveness of these initiatives, AIP growth appears to have levelled off.

(ii) Risks by Discount/Surcharge Category

Table 46 shows the distribution of New York private passenger assigned risk liability and physical damage earned car years by discount/surcharge category for 1989, 1990 and 1991.

(iii) Risks by Rating Territory

The proportion of all private passenger assigned risk liability earned car years to total earned car years by rating territory, for 1990 and 1991, is shown in Table 47. This ratio was 10% or higher in 41 of the 70 rating territories in 1990 and in 37 of the 70 in 1991. The 1991 ratios ranged from a low of 4.4% in the Saratoga South Territory to a high of 81.7% in the Bronx Territory. Between 1990 and 1991 the ratios increased in 21 of the 70 rating territories, decreased in 45 rating territories, and remained the same in 4 rating territories. The congested urban areas of New York City consistently produced the highest ratios in the State.

Table 48 displays a ten-year history of the percentage of assigned risks to total earned car years by territory, ranked from highest to lowest.

Table 44

Policies Written Under New York Automobile Insurance Plan 1991 and 1992

Period	Original Policies	Renewal Policies	Cancellations	Net Policies Written[a]	Percent Change
Liability Only[b]					
1991	1,353,123	1,033,936	1,134,899	1,252,160	
1992	1,210,587	964,552	973,857	1,201,282	-4.1%
Physical Damage Only[b]					
1991	5,164	4,995	4,641	5,518	
1992	1,762	1,281	1,345	1,698	-69.2
Liability and Physical Damage Written Together[b]					
1991	158,569	152,777	138,562	172,784	
1992	106,376	73,767	55,995	124,148	-28.1
Total All Policies					
1991	1,516,856	1,191,708	1,278,102	1,430,462	
1992	1,318,725	1,039,600	1,031,197	1,327,128	-7.2

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[a] Net policies written is the sum of original policies and renewal policies less cancellations.

[b] Policies are written for liability and physical damage separately as well as for liability and physical damage combined.

Source: Data from New York State-licensed insurers reporting to the Automobile Insurance Plans Service Office (subject to verification).

Table 45

Earned Car Years, Voluntary Liability and Assigned Risk Liability and Physical Damage 1982-1991

Calendar Year	Voluntary Liability	Change From Previous Year	Assigned Risk Liability	Change From Previous Year	Combined Liability	Change From Previous Year	Assigned Risk Physical Damage	Change From Previous Year
1982	5,112,101		766,276		5,878,377		105,626	
1983	5,749,777	12.5%	784,195	2.3%	6,533,972	11.2%	77,163	-26.9%
1984	5,779,246	0.5	784,883	0.1	6,564,129	0.5	60,517	-21.6
1985	5,950,717	3.0	867,917	10.6	6,818,634	3.9	54,110	-10.6
1986	6,038,283	1.5	1,022,690	17.8	7,060,973	3.6	63,975	18.2
1987	6,241,010	3.4	1,173,197	14.7	7,414,207	5.0	83,019	29.8
1988	6,474,315	3.7	1,262,811	7.6	7,737,126	4.4	93,237	12.3
1989	6,427,253	-0.7	1,285,315	1.8	7,712,568	-0.3	112,538	20.7
1990	6,472,573	0.7	1,322,054	2.9	7,794,627	1.1	124,142	10.3
1991	6,585,328	1.7	1,321,828	0.0	7,907,156	1.4	108,409	-12.7

Table 46
Distribution of Private Passenger Liability and Collision Assigned Risks by Discount/Surcharge Category
1989-1991

Discount/Surcharge Category	1989	1990	1991	1989	1990	1991
Total, all categories	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total unsurcharged	63.7	63.1	63.2	61.3	61.7	63.0
Manually rated	5.5	5.7	8.9	6.4	4.8	7.6
3 Years claim free (none with Plan)	33.2	32.5	30.4	34.4	33.5	30.7
Experience discount						
4 Years - 18% credit	12.3	12.1	11.6	11.5	12.6	13.0
5 Years - 25% credit	7.3	6.9	6.3	6.3	6.9	7.1
6 Years - 30% credit or more	5.4	5.9	6.0	2.7	3.9	4.6
Total surcharged	36.3	36.9	36.8	38.7	38.3	37.0
Inexperience operator	15.9	15.1	14.9	11.8	11.0	9.2
Experience surcharged						
15%	11.0	11.4	12.0	14.0	15.5	16.0
25	0.0	0.0	0.0	0.2	0.0	0.0
35	3.3	3.4	3.4	5.1	5.1	5.2
50	1.2	1.3	1.3	1.4	1.4	1.5
75	1.9	1.8	1.7	2.5	2.4	2.3
100-150	3.0	3.9	3.5	3.7	2.9	2.8

Source: Automobile Insurance Plans Service Office

Table 47

Private Passenger Earned Car Years by Voluntary, Assigned Risk and Combined Markets
(Including Ranking by Percentage of Risks Placed in the Plan)
1990 and 1991

	1990								1991														
Territory	Assigned Risks	% of Total	Voluntary Risks	% of Total	Combined Risks	% of Total	A/R as % of Comb.	RANK	Assigned Risks	% of Total	Chg. from 1990	% Chg.	Voluntary Risks	% of Total	Chg. from 1990	% Chg.	Combined Risks	% of Total	Chg. from 1990	% Chg.	A/R as % of Comb.	RANK
01 Bronx Territory	38,077	2.9	8,566	0.1	46,643	0.6	81.6	1	37,616	2.8	−461	−1.2	8,410	0.1	−156	−1.9	46,026	0.6	−617	−1.3	81.7	1
19 Queens	28,656	2.2	23,102	0.4	51,758	0.7	55.4	2	28,170	2.1	−486	−1.7	25,184	0.4	2082	8.3	53,354	0.7	1596	3.0	52.8	2
18 Manhattan	60,413	4.6	71,130	1.1	131,543	1.7	45.9	4	61,166	4.6	753	1.2	71,207	1.1	77	0.1	132,373	1.7	830	0.6	46.2	3
03 Bronx Suburban Terr.	73,855	5.6	87,794	1.4	161,649	2.1	45.7	5	73,339	5.5	−516	−0.7	86,138	1.3	−1656	−1.9	159,477	2.0	−2172	−1.4	46.0	4
17 Kings County	163,360	12.4	191,438	3.0	354,798	4.6	46.0	3	158,183	12.0	−5177	−3.3	192,584	2.9	1146	0.6	350,767	4.4	−4031	−1.1	45.1	5
55 Queens Suburban	181,817	13.8	343,366	5.3	525,183	6.7	34.6	6	181,208	13.7	−609	−0.3	334,251	5.1	−9115	−2.7	515,459	6.5	−9724	−1.9	35.2	6
94 Mt. Vernon & Yonkers	27,335	2.1	77,568	1.2	104,903	1.3	26.1	7	26,809	2.0	−526	−2.0	77,154	1.2	−414	−0.5	103,963	1.3	−940	−0.9	25.8	7
82 Sullivan Co. Central	2,598	0.2	9,378	0.1	11,976	0.2	21.7	8	2,571	0.2	−27	−1.1	9,552	0.1	174	1.8	12,123	0.2	147	1.2	21.2	8
05 Staten Island	30,054	2.3	151,364	2.3	181,418	2.3	16.6	9	31,797	2.4	1743	5.8	151,998	2.3	634	0.4	183,795	2.3	2377	1.3	17.3	9
75 Suffolk County West	78,532	5.9	412,128	6.4	490,660	6.3	16.0	11	76,827	5.8	−1705	−2.2	409,247	6.2	−2881	−0.7	486,074	6.1	−4586	−0.9	15.8	10
76 Suffolk County East	57,881	4.4	310,319	4.8	368,200	4.7	15.7	13	58,937	4.5	1056	1.8	314,557	4.8	4238	1.3	373,494	4.7	5294	1.4	15.8	11
83 Sullivan Co. (Balance)	3,036	0.2	15,954	0.2	18,990	0.2	16.0	12	2,984	0.2	−52	−1.7	16,511	0.3	557	3.4	19,495	0.2	505	2.5	15.3	12
07 Buffalo	17,947	1.4	105,698	1.6	123,645	1.6	14.5	17	18,439	1.4	492	2.7	102,041	1.5	−3657	−3.6	120,480	1.5	−3165	−2.6	15.3	13
97 New York City Sub.	29,120	2.2	172,977	2.7	202,097	2.6	14.4	18	29,243	2.2	123	0.4	166,225	2.5	−6752	−4.1	195,468	2.5	−6629	−3.4	15.0	14
20 Hempstead	64,980	4.9	381,938	5.9	446,918	5.7	14.5	14	66,477	5.0	1497	2.3	379,414	5.8	−2524	−0.7	445,891	5.6	−1027	−0.2	14.9	15
37 Oswego	5,304	0.4	26,795	0.4	32,099	0.4	16.5	10	5,052	0.4	−252	−5.0	29,204	0.4	2409	8.2	34,256	0.4	2157	6.3	14.7	16
64 Middletown	17,148	1.3	105,986	1.6	123,134	1.6	13.9	20	16,763	1.3	−385	−2.3	102,058	1.5	−3928	−3.8	118,821	1.5	−4313	−3.6	14.1	17
29 Gloversville	3,774	0.3	22,218	0.3	25,992	0.3	14.5	16	3,676	0.3	−98	−2.7	22,554	0.3	336	1.5	26,230	0.3	238	0.9	14.0	18
62 Highland, Kingston	10,462	0.8	62,235	1.0	72,697	0.9	14.4	19	10,296	0.8	−166	−1.6	64,127	1.0	1892	3.0	74,423	0.9	1726	2.3	13.8	19
61 Monticello–Liberty	1,662	0.1	9,778	0.2	11,440	0.1	14.5	15	1,638	0.1	−24	−1.5	10,441	0.2	663	6.3	12,079	0.2	639	5.3	13.6	20
36 Glens Falls	4,592	0.3	29,049	0.4	33,641	0.4	13.7	21	4,587	0.3	−5	−0.1	30,432	0.5	1383	4.5	35,019	0.4	1378	3.9	13.1	21
34 Troy	7,026	0.5	45,117	0.7	52,143	0.7	13.5	22	7,016	0.5	−10	−0.1	46,886	0.7	1769	3.8	53,902	0.7	1759	3.3	13.0	22
33 Poughkeepsie	11,530	0.9	74,770	1.2	86,300	1.1	13.4	23	11,224	0.8	−306	−2.7	76,663	1.2	1893	2.5	87,887	1.1	1587	1.8	12.8	23
67 Clinton County, etc.	36,472	2.8	248,584	3.8	285,056	3.7	12.8	25	35,800	2.7	−672	−1.9	252,473	3.8	3889	1.5	288,273	3.6	3217	1.1	12.4	24
66 Rockland County	19,962	1.5	145,421	2.2	165,383	2.1	12.1	30	20,150	1.5	188	0.9	147,084	2.2	1663	1.1	167,234	2.1	1851	1.1	12.0	25
46 Putnam County	7,312	0.6	52,277	0.8	59,589	0.8	12.3	29	7,281	0.6	−31	−0.4	54,028	0.8	1751	3.2	61,309	0.8	1720	2.8	11.9	26
21 North Hempstead	17,323	1.3	132,827	2.1	150,150	1.9	11.5	32	17,852	1.4	529	3.0	132,524	2.0	−303	−0.2	150,376	1.9	226	0.2	11.9	27
58 Dutchess County (Bal.)	9,797	0.7	69,526	1.1	79,323	1.0	12.4	28	9,529	0.7	−268	−2.8	70,913	1.1	1387	2.0	80,442	1.0	1119	1.4	11.8	28
74 Jefferson County	7,345	0.6	52,101	0.8	59,446	0.8	12.4	27	7,207	0.5	−138	−1.9	53,905	0.8	1804	3.3	61,112	0.8	1666	2.7	11.8	29
65 Ossining	17,745	1.3	142,686	2.2	160,431	2.1	11.1	34	17,992	1.4	247	1.4	142,977	2.2	291	0.2	160,969	2.0	538	0.3	11.2	30
14 Niagara Falls	7,631	0.6	63,592	1.0	71,223	0.9	10.7	37	7,723	0.6	92	1.2	62,584	1.0	−1008	−1.6	70,307	0.9	−916	−1.3	11.0	31
22 Oyster Bay	24,219	1.8	198,565	3.1	222,784	2.9	10.9	35	24,629	1.9	410	1.7	200,141	3.0	1576	0.8	224,770	2.8	1986	0.9	11.0	32
96 White Plains	5,293	0.4	35,230	0.5	40,523	0.5	13.1	24	5,542	0.4	249	4.5	45,881	0.7	10651	23.2	51,423	0.7	10900	21.2	10.8	33
32 Newburgh	6,926	0.5	47,822	0.7	54,748	0.7	12.7	26	6,717	0.5	−209	−3.1	56,053	0.9	8231	14.7	62,770	0.8	8022	12.8	10.7	34
13 Albany	15,249	1.2	126,611	2.0	141,860	1.8	10.7	36	15,687	1.2	438	2.8	131,956	2.0	5345	4.1	147,643	1.9	5783	3.9	10.6	35

	1990									1991														
Territory	Assigned Risks	% of Total	Voluntary Risks	% of Total	Combined Risks	% of Total	A/R as % of Comb.	RANK		Assigned Risks	% of Total	Chg. from 1990	% Chg.	Voluntary Risks	% of Total	Chg. from 1990	% Chg.	Combined Risks	% of Total	Chg. from 1990	% Chg.	A/R as % of Comb.	RANK
61 Delaware County, etc.	12,495	0.9	113,802	1.8	126,297	1.6	9.9	42		13,110	1.0	615	4.7	111,631	1.7	−2171	−1.9	124,741	1.6	−1556	−1.2	10.5	36
47 Orleans County	2,678	0.2	21,379	0.3	24,057	0.3	11.1	33		2,569	0.2	−109	−4.2	22,190	0.3	811	3.7	24,759	0.3	702	2.8	10.4	37
54 Cortland County, etc.	18,985	1.4	162,655	2.5	181,640	2.3	10.5	38		18,766	1.4	−219	−1.2	170,101	2.6	7446	4.4	188,867	2.4	7227	3.8	9.9	38
64 Allegany County, etc.	16,488	1.2	150,691	2.3	167,179	2.1	9.9	43		16,704	1.3	216	1.3	155,021	2.4	4330	2.8	171,725	2.2	4546	2.6	9.7	39
51 Ontario County, etc.	16,018	1.2	147,694	2.3	163,712	2.1	9.8	44		15,940	1.2	−78	−0.5	152,134	2.3	4440	2.9	168,074	2.1	4362	2.6	9.5	40
12 Syracuse	19,585	1.5	193,802	3.0	213,387	2.7	9.2	47		20,469	1.5	884	4.3	199,256	3.0	5454	2.7	219,725	2.8	6338	2.9	9.3	41
59 Columbia County, etc.	6,678	0.5	61,803	1.0	68,481	0.9	9.8	45		6,686	0.5	8	0.1	65,495	1.0	3692	5.6	72,181	0.9	3700	5.1	9.3	42
43 Niagara Falls Sub.	2,905	0.2	28,225	0.4	31,130	0.4	9.3	46		2,927	0.2	22	0.8	29,069	0.4	844	2.9	31,996	0.4	866	2.7	9.1	43
56 Saratoga County (Bal.)	2,212	0.2	19,023	0.3	21,235	0.3	10.4	39		2,131	0.2	−81	−3.8	21,497	0.3	2474	11.5	23,628	0.3	2393	10.1	9.0	44
30 Saratoga Springs	1,656	0.1	14,277	0.2	15,933	0.2	10.4	40		1,658	0.1	2	0.1	16,900	0.3	2623	15.5	18,558	0.2	2625	14.1	8.9	45
52 Fort Plain, Herkimer	3,436	0.3	34,939	0.5	38,375	0.5	9.0	49		3,413	0.3	−23	−0.7	35,164	0.5	225	0.6	38,577	0.5	202	0.5	8.8	46
73 Rensselaer County (Bal.)	3,053	0.2	31,328	0.5	34,381	0.4	8.9	50		3,068	0.2	15	0.5	31,750	0.5	422	1.3	34,818	0.4	437	1.3	8.8	47
31 Chautauqua County	7,145	0.5	72,379	1.1	79,524	1.0	9.0	48		7,135	0.5	−10	−0.1	74,499	1.1	2120	2.8	81,634	1.0	2110	2.6	8.7	48
11 Rochester	31,558	2.4	340,598	5.3	372,156	4.8	8.5	55		33,068	2.5	1510	4.6	346,215	5.3	5617	1.6	379,283	4.8	7127	1.9	8.7	49
09 Schenectady County	8,197	0.6	84,515	1.3	92,712	1.2	8.8	51		8,274	0.6	77	0.9	87,208	1.3	2693	3.1	95,482	1.2	2770	2.9	8.7	50
16 Saratoga Springs Sub.	3,105	0.2	36,306	0.6	39,411	0.5	7.9	60		3,191	0.2	86	2.7	34,226	0.5	−2080	−6.1	37,417	0.5	−1994	−5.3	8.5	51
66 Oneida	3,374	0.3	36,317	0.6	39,691	0.5	8.5	54		3,389	0.3	15	0.4	36,366	0.6	49	0.1	39,755	0.5	64	0.2	8.5	52
41 Erie County (Balance)	5,407	0.4	46,990	0.7	52,397	0.7	10.3	41		5,347	0.4	−60	−1.1	57,400	0.9	10410	18.1	62,747	0.8	10350	16.5	8.5	53
44 Broome County (Bal.)	1,299	0.1	13,488	0.2	14,787	0.2	8.8	52		1,228	0.1	−71	−5.8	13,899	0.2	411	3.0	15,127	0.2	340	2.2	8.1	54
72 Albany Co. (Balance)	885	0.1	9,575	0.1	10,460	0.1	8.5	56		852	0.1	−33	−3.9	9,751	0.1	176	1.8	10,603	0.1	143	1.3	8.0	55
46 Monroe Co. Balance	1,382	0.1	10,318	0.2	11,700	0.2	11.8	31		1,422	0.1	40	2.8	16,564	0.3	6246	37.7	17,986	0.2	6286	34.9	7.9	56
60 Genesee County	3,056	0.2	33,928	0.5	36,984	0.5	8.3	57		2,999	0.2	−57	−1.9	35,009	0.5	1081	3.1	38,008	0.5	1024	2.7	7.9	57
25 Auburn	2,154	0.2	22,942	0.4	25,096	0.3	8.6	53		2,105	0.2	−49	−2.3	24,684	0.4	1742	7.1	26,789	0.3	1693	6.3	7.9	58
42 Buffalo Suburban	12,985	1.0	153,202	2.4	166,187	2.1	7.8	61		13,174	1.0	189	1.4	155,362	2.4	2160	1.4	168,536	2.1	2349	1.4	7.8	59
35 Amsterdam	1,611	0.1	18,705	0.3	20,316	0.3	7.9	59		1,600	0.1	−11	−0.7	19,079	0.3	374	2.0	20,679	0.3	363	1.8	7.7	60
49 Niagara County (Bal.)	2,053	0.2	23,348	0.4	25,401	0.3	8.1	58		2,274	0.2	221	9.7	27,196	0.4	3848	14.1	29,470	0.4	4069	13.8	7.7	61
28 Binghamton	8,929	0.7	107,295	1.7	116,224	1.5	7.7	62		9,098	0.7	169	1.9	112,079	1.7	4784	4.3	121,177	1.5	4953	4.1	7.5	62
15 Utica	3,728	0.3	54,538	0.8	58,266	0.7	6.4	66		3,782	0.3	54	1.4	47,351	0.7	−7187	−15.2	51,133	0.6	−7133	−13.9	7.4	63
08 Buffalo Semi-Sub.	11,728	0.9	167,776	2.6	179,504	2.3	6.5	64		12,450	0.9	722	5.8	172,683	2.6	4907	2.8	185,133	2.3	5629	3.0	6.7	64
40 Corning	1,383	0.1	19,119	0.3	20,502	0.3	6.7	63		1,336	0.1	−47	−3.5	19,092	0.3	−27	−0.1	20,428	0.3	−74	−0.4	6.5	65
38 Syracuse Suburban	2,626	0.2	43,008	0.7	45,634	0.6	5.8	68		2,638	0.2	12	0.5	42,961	0.7	−47	−0.1	45,599	0.6	−35	−0.1	5.8	66
39 Rochester Suburban	2,331	0.2	40,143	0.6	42,474	0.5	5.5	69		2,295	0.2	−36	−1.6	37,969	0.6	−2174	−5.7	40,264	0.5	−2210	−5.5	5.7	67
27 Elmira	2,341	0.2	41,762	0.6	44,103	0.6	5.3	70		2,467	0.2	126	5.1	43,659	0.7	1897	4.3	46,126	0.6	2023	4.4	5.3	68
24 Rome	2,063	0.2	32,647	0.5	34,710	0.4	5.9	67		2,036	0.2	−27	−1.3	38,852	0.6	6205	16.0	40,888	0.5	6178	15.1	5.0	69
71 Saratoga Co. South	2,092	0.2	30,146	0.5	32,238	0.4	6.5	65		2,100	0.2	8	0.4	45,659	0.7	15513	34.0	47,759	0.6	15521	32.5	4.4	70
Entire State	1,322,054	100.0	6,472,573	100.0	7,794,627	100.0	17.0			1,321,828	100.0	(226)		6,585,328	100.0	112,755		7,907,156	100.0	112,529		16.7	

Source: Derived from data provided by the Automobile Insurance Plans Service Office.

Table 48

Percentage of All Private Passenger Automobiles Insured Through the New York Automobile Insurance Plan by Territory
1982 – 1991

Territory		1982	#	1983	#	1984	#	1985	#	1986	#	1987	#	1988	#	1989	#	1990	#	1991	#
01	Bronx Territory	59.7	1	65.3	1	69.1	1	71.2	1	76.8	1	79.2	1	79.7	1	81.1	1	81.6	1	81.7	1
19	Queens	33.3	3	36.9	2	41.5	2	45.9	2	51.7	2	54.5	2	54.5	2	55.1	2	55.4	2	52.8	2
16	Manhattan	36.1	2	35.9	3	36.2	3	38.1	3	41.3	3	43.0	3	43.7	3	45.2	4	45.9	4	46.2	3
03	Bronx Suburban Territory	30.9	4	30.7	4	31.1	4	33.4	4	37.6	5	40.7	5	42.1	5	44.2	5	45.7	5	46.0	4
17	Kings County	26.6	5	29.4	5	30.3	5	33.2	5	38.8	4	42.5	4	43.4	4	45.4	3	46.0	3	45.1	5
55	Queens Suburban	21.8	6	22.1	6	22.9	6	24.6	6	28.0	6	30.6	6	32.1	6	33.7	6	34.6	6	35.2	6
94	Mount Vernon and Yonkers	19.1	8	17.3	7	17.3	7	18.4	7	21.2	7	23.2	7	24.0	7	25.1	7	26.1	7	25.8	7
82	Sullivan County Central	19.9	7	16.3	8	14.5	8	15.9	8	17.7	8	19.9	8	20.4	8	21.3	8	21.7	8	21.2	8
05	Staten Island	13.7	13	12.3	13	11.4	14	12.3	12	14.5	11	15.5	11	15.8	12	16.1	10	16.6	9	17.3	9
75	Suffolk County West	14.6	12	13.4	11	13.6	10	13.9	10	15.1	10	16.0	10	16.1	9	16.1	12	16.0	11	15.8	10
76	Suffolk County East	15.2	10	13.8	10	13.6	9	14.2	9	15.4	9	16.1	9	16.1	10	15.9	13	15.7	13	15.8	11
83	Sullivan County (Balance)	15.0	11	13.3	12	12.2	11	11.9	14	12.9	17	14.1	17	14.5	15	15.1	14	16.0	12	15.3	12
07	Buffalo	13.0	15	10.9	17	10.5	18	10.8	17	13.4	14	14.3	15	14.0	17	14.1	19	14.5	17	15.3	13
97	New York City Suburban	10.6	24	9.5	24	9.4	22	9.7	24	11.2	23	12.2	24	12.5	25	13.2	23	14.4	18	15.0	14
20	Hempstead	11.7	18	11.2	16	11.3	15	11.5	16	13.0	16	14.1	16	14.4	16	14.5	16	14.5	14	14.9	15
37	Oswego	13.1	14	12.1	14	11.9	13	12.5	11	13.4	13	15.0	12	16.0	11	16.2	9	16.5	10	14.7	16
64	Middletown	11.4	20	9.8	21	9.7	21	10.7	19	12.2	18	13.1	19	13.5	21	13.6	21	13.9	20	14.1	17
29	Gloversville	9.9	30	8.7	27	8.3	27	8.8	27	10.4	29	11.9	26	13.4	22	14.2	17	14.5	16	14.0	18
62	Highland, Kingston	11.1	21	9.8	22	9.0	25	10.1	22	12.0	19	13.3	18	13.9	18	14.1	18	14.4	19	13.8	19
81	Monticello–Liberty	16.6	9	14.0	9	12.0	12	12.0	13	13.8	12	15.0	13	15.7	13	16.1	11	14.5	15	13.6	20
36	Glens Falls	7.8	46	6.2	47	5.8	51	6.9	44	9.5	33	12.0	25	13.7	19	13.9	20	13.7	21	13.1	21
34	Troy	8.0	44	7.1	38	7.7	31	8.7	29	11.0	24	12.4	22	13.4	23	13.3	22	13.5	22	13.0	22
33	Poughkeepsie	10.9	23	9.5	23	9.2	23	10.3	21	11.6	21	12.7	20	13.1	24	13.2	24	13.4	23	12.8	23
87	Clinton County, etc.	9.8	31	8.5	29	8.2	29	8.8	28	10.4	28	11.8	27	12.3	28	12.7	25	12.8	25	12.4	24
88	Rockland County	10.9	22	10.0	20	9.6	19	10.3	20	11.6	20	12.3	23	12.4	26	12.3	28	12.1	30	12.0	25
46	Putnam County	12.0	17	10.2	19	9.7	20	10.0	23	10.8	25	11.7	28	11.9	31	12.1	31	12.3	29	11.9	26
21	North Hempstead	10.4	25	9.4	25	9.2	24	9.3	25	10.4	27	11.3	33	11.3	33	11.3	33	11.5	32	11.9	27
58	Dutchess County (Balance)	9.8	32	8.7	28	8.2	28	8.9	26	10.2	30	11.6	30	12.1	30	12.4	27	12.4	28	11.8	28
74	Jefferson County	10.3	27	8.3	32	7.6	33	8.2	32	10.0	32	11.5	32	12.4	27	12.1	30	12.4	27	11.8	29
65	Ossining	10.3	26	9.1	26	8.4	26	8.5	31	9.4	35	10.2	37	10.7	37	10.8	36	11.1	34	11.2	30
14	Niagara Falls	7.7	47	7.1	40	7.0	39	7.2	40	9.0	39	10.6	38	11.1	35	10.8	35	10.7	37	11.0	31
22	Oyster Bay	11.5	19	10.6	18	10.6	17	10.7	18	11.3	22	11.6	29	11.3	34	11.0	34	10.9	35	11.0	32
95	White Plains	13.0	16	11.6	15	10.9	16	11.7	15	13.2	15	14.3	14	14.6	14	14.8	15	13.1	24	10.8	33
32	Newburgh	10.0	28	8.1	33	7.5	34	8.5	30	10.1	31	11.5	31	12.1	29	12.6	26	12.7	26	10.7	34
15	Albany	7.0	53	6.3	46	6.5	44	7.0	43	8.4	42	9.7	41	10.3	39	10.5	39	10.7	38	10.8	35

Territory	1982	#	1983	#	1984	#	1985	#	1986	#	1987	#	1988	#	1989	#	1990	#	1991	#
61 Delaware County, etc.	8.5	39	7.0	43	6.5	45	6.7	48	7.6	49	8.9	46	9.6	45	9.7	45	9.9	42	10.5	36
47 Orleans County	9.9	29	8.4	30	7.7	32	7.8	36	9.0	37	10.7	35	11.5	32	11.4	32	11.1	33	10.4	37
54 Cortland County, etc.	8.8	36	7.0	42	6.6	41	7.1	41	8.6	41	10.0	38	10.6	38	10.7	37	10.5	38	9.9	38
64 Allegany County, etc.	9.6	34	7.9	34	7.2	35	7.5	39	8.3	43	9.3	43	9.9	43	9.9	43	9.9	43	9.7	39
51 Ontario County, etc.	8.1	43	7.0	41	7.0	38	7.7	38	8.9	40	9.8	40	10.0	41	10.1	41	9.8	44	9.5	40
12 Syracuse	6.8	57	5.8	51	6.1	48	6.8	46	8.0	46	8.8	47	8.9	50	8.9	50	9.2	47	9.3	41
59 Columbia County, etc.	9.8	33	8.3	31	7.8	30	8.0	35	9.1	36	9.9	39	9.8	44	9.7	44	9.8	45	9.3	42
43 Niagara Falls Suburban	8.4	40	6.7	44	7.1	36	7.7	37	9.0	38	9.1	45	9.4	46	9.5	46	9.3	46	9.1	43
56 Saratoga County (Balance)	5.8	66	5.9	49	6.5	43	8.0	33	10.6	26	12.6	21	13.5	20	12.2	29	10.4	39	9.0	44
30 Saratoga Springs	7.0	54	5.6	55	5.0	61	5.8	53	8.1	45	9.6	42	10.0	42	10.0	42	10.4	40	8.9	45
52 Fort Plain, Herkimer	6.4	59	5.7	54	5.8	52	6.3	50	7.4	50	8.5	50	8.6	52	8.8	52	9.0	49	8.8	46
73 Rensselaer County (Balance)	7.3	51	5.4	58	5.2	58	5.6	58	6.9	53	8.2	52	9.0	48	9.1	48	8.9	50	8.8	47
31 Chautauqua County	7.6	48	5.8	52	4.9	63	5.5	59	6.7	57	8.1	53	8.6	53	9.0	49	9.0	48	8.7	48
11 Rochester	5.5	68	4.8	65	4.7	65	5.2	63	6.3	62	7.4	62	8.0	58	8.2	55	8.5	55	8.7	49
09 Schenectady County	6.9	56	6.2	48	6.1	47	6.7	47	8.0	48	8.7	49	8.9	51	8.8	51	8.8	51	8.7	50
16 Saratoga Springs Suburban	5.9	64	4.5	67	4.4	67	4.9	67	6.5	60	7.8	57	7.9	59	7.7	61	7.9	60	8.5	51
66 Oneida	8.7	37	7.1	39	6.6	42	6.6	49	7.4	51	7.9	54	8.3	54	8.2	54	8.5	54	8.5	52
41 Erie County (Balance)	8.1	42	7.3	36	7.0	37	8.0	34	9.5	34	11.0	34	10.9	36	10.5	38	10.3	41	8.5	53
44 Broome County (Balance)	7.2	52	5.7	53	6.3	46	7.0	42	8.1	44	8.8	48	9.0	49	8.6	53	8.8	52	8.1	54
72 Albany County (Balance)	7.4	50	5.5	57	5.3	55	5.6	56	6.7	58	8.4	51	9.2	47	9.1	47	8.5	56	8.0	55
48 Monroe County Balance	9.3	35	7.4	35	6.9	40	6.9	45	8.0	47	9.2	44	10.1	40	10.3	40	11.8	31	7.9	56
60 Genesee County	7.9	45	6.5	45	5.9	50	5.8	52	6.6	59	7.8	58	8.1	56	8.1	56	8.3	57	7.9	57
25 Auburn	7.4	49	5.1	61	5.0	62	5.4	60	6.7	55	7.5	61	7.8	62	8.0	58	8.6	53	7.9	58
42 Buffalo Suburban	5.9	62	5.3	60	5.3	56	5.8	54	6.9	54	7.6	60	7.8	60	7.9	59	7.8	61	7.8	59
35 Amsterdam	7.0	55	5.5	56	5.7	53	5.8	55	6.7	56	7.8	36	8.1	57	7.7	62	7.9	59	7.7	60
49 Niagara County (Balance)	8.2	41	5.8	50	5.5	54	5.6	57	6.4	61	7.6	59	7.8	61	8.0	57	8.1	58	7.7	61
26 Binghamton	5.7	67	5.0	63	5.1	60	5.3	61	6.0	64	6.8	63	7.2	63	7.5	63	7.7	62	7.5	62
15 Utica	4.9	70	3.8	70	3.6	70	3.8	69	4.6	69	5.2	69	5.5	69	5.5	69	6.4	66	7.4	63
06 Buffalo Semi–Suburban	5.9	63	4.9	64	4.7	64	5.0	65	6.1	63	6.7	64	6.8	65	6.7	66	6.5	64	6.7	64
40 Corning	6.7	58	4.7	66	4.5	66	5.1	64	5.9	65	6.4	65	6.7	66	6.7	64	6.7	63	6.5	65
38 Syracuse Suburban	5.8	65	5.1	62	5.3	57	5.3	62	5.6	66	6.1	67	6.0	67	5.9	67	5.8	68	5.8	66
39 Rochester Suburban	6.0	61	5.3	59	5.2	59	5.0	66	5.3	67	5.7	68	5.8	68	5.6	68	5.5	69	5.7	67
27 Elmira	6.0	60	4.3	68	3.8	69	3.7	70	4.2	70	4.8	70	4.8	70	4.8	70	5.3	70	5.3	68
24 Rome	8.6	38	7.2	37	6.0	49	6.1	51	7.0	52	7.9	55	8.1	55	7.9	60	5.9	67	5.0	69
71 Saratoga County South	5.0	69	4.1	69	4.0	68	4.4	68	5.2	68	6.2	66	6.8	64	6.7	65	6.5	65	4.4	70
Entire State	**13.0**		**12.0**		**12.0**		**12.7**		**14.5**		**15.8**		**16.3**		**16.7**		**17.0**		**16.7**	

Source: Derived from data provided by the Automobile Insurance Plans Service Office.

= Rank from highest to lowest concentration

3. Workers' Compensation

a. 1992 Rate Increase

Effective July 1,1992, the Department approved an increase of 15.6% for the members and subscribers of the New York Compensation Insurance Rating Board (NYCIRB).

For the first time the workers' compensation rate includes a loss based assessment, interdepartmental expenses, which is related to a Department of Labor program responsible for enforcing Occupational Safety and Health Act (OSHA) regulations. Of the 15.6% increase, almost 4% was the result of increases in the loss assessments alone. Another 5% was the result of benefit changes. Therefore, more than half of the increase was due to factors outside of the insurance mechanism.

b. Temporary Commission

The Temporary Commission on Workers' Compensation Ratesetting, established by legislation in 1990, published its final report in December 1992. Department actuaries represented the Superintendent (an ex-officio member) at Commission meetings, and supplied technical expertise and assistance. Recommendations affecting the Insurance Department included developing a merit rating plan for small insureds, establishing guidelines for an independent examination of the New York Compensation Insurance Rating Board, updating Regulation 70, entitled "Methodologies for Measuring the Profitability of Property and Liability Insurance Lines Written in New York," removing certain statutory assessments from the ratemaking process, and implementing a Premium Adjustment Plan designed to reduce premiums paid by certain employers with highly-paid employees.

A Task Force to update Regulation 70 was appointed by the NYCIRB and has begun meeting with the Department. Legislation to remove the cost of statutory assessments from the ratemaking process has been introduced in the current session.

c. Premium Adjustment Plan

One of the recommendations of the Temporary Commission was the approval of the Premium Adjustment Program. The purpose of the Premium Adjustment Program is to provide rating credits to those construction employers that pay more than a given amount in hourly wages. Since workers' compensation premiums are based on payroll, higher-paying employers in construction trades often pay more in workers' compensation premiums than their low-paying counterparts. This discrepancy in premiums is not fully accounted for by the additional benefits afforded, experience rating modifications and premium discounts. The Premium Adjustment Program is designed to address the rate inequities for this specific group of employers.

d. Annual Rate Revision Effective Date

Legislation enacted in 1992 (to take effect in 1993) will mandate a 75-day period between approval of the annual rate revision (on or before July 15 of each year) and the effective date of the revision (October 1 of each year).

e. Large Deductible Programs

Numerous Large Deductible Programs have been approved in response to the 1990 amendment to the statute governing Workers' Compensation ratemaking. In 1992, twenty such filings were approved.

Since the institution of these filings, all Programs have been available to insureds with standard premium of $500,000 or more. The main argument given by the insurers that first filed for these Programs was that it would allow insurers to compete with self-insurance. The Department, at that time, consulted with the Self-Insurance Office of the Workers' Compensation Board to determine which potential insureds could be affected by approval of these filings. We were informed that the smallest amount a company would have to put up to be self-insured in New York was $460,000. We equated this amount to the loss portion of a given premium. Such annual premium would be about $275,000. We determined, therefore, that requiring a minimum premium of $500,000 would insure that the Programs would target those insureds that would be able to leave the insurance market for self-insurance.

In 1992, for the first time, the Department approved for use a Large Deductible Program for insureds with standard premium lower than $500,000. The $250,000 minimum premium that was approved is very close to the minimum an insurer would have to put up to be a self-insurer acceptable to the Workers' Compensation Board.

The Department recognizes that this change affords the opportunity for this type of Program to smaller, and perhaps less sophisticated, insureds. In view of this, the approved Program must be offered with a required aggregate limit, of three times the standard premium. In this way the Department assures a dollar amount above which the insured cannot be responsible.

Additionally, the premium tax paid on policies in this Program for insureds, $250,000 to $500,000 will be paid on a first dollar basis rather than only the actual premium paid to the insurer. This modification to the Program was made in recognition of the pending Department decision concerning premium tax on these policies. The decision has since been published in the March 1993 edition of The Bulletin.

TABLE 49

WORKERS' COMPENSATION RATE HISTORY

EFFECTIVE DATE	FILED	APPRVD	POLICY YEAR	CAL YEAR	LAW AMEND. & MEDICAL & HOSP AGREEMENTS	WAGE & L/R TREND FACTOR	W.C.B. ASS'M'T	S.D.F. & R.C.F. ASS'M'T	LOSS CONSTANT OFFSET	EXPENSES	OVERALL EFFECT FILED	OVERALL EFFECT APPRVD	STOCK SECRTY FUND TAX
July, 1980	−3.1%	−10.1%	−4.5%	−7.1%	0.0%	1.0133	−0.1%	−2.5%	0.8%	−4.1%	−3.1%	−10.1%	
Oct, 1980	2.9%	2.9%									−0.9%	−7.5%	
July, 1981	−14.3%	−20.4%	−11.5%	−11.5%	7.7%	0.8600	−0.4%	0.3%	0.3%	−3.1%	−14.5%	−26.4%	
July, 1982	−2.1%	−3.4%	−4.6%	−11.7%	4.3%	0.9895	0.1%	1.2%	0.2%	0.3%	−16.3%	−28.9%	
July, 1983	5.4%	−2.0%	−0.3%	−7.8%	19.5%	0.8807	0.1%	−4.1%	0.0%	−0.1%	−11.8%	−30.3%	1.012
July, 1984	9.4%	8.1%	6.6%	3.5%	7.8%	0.8979	0.1%	2.6%	−0.3%	3.8%	−3.5%	−24.6%	
July, 1985	14.2%	10.2%	7.7%	0.9%	8.3%	0.9725	−0.3%	−1.5%	0.0%	2.2%	10.2%	−17.0%	
July, 1986	1.5%	−4.7%	−1.3%	−8.4%	3.8%	0.9257	0.2%	1.0%	0.0%	3.0%	11.8%	−20.9%	
July, 1987	6.5%	5.1%	7.5%	12.8%	2.2%	0.9134	0.3%	0.5%	0.0%	0.4%	19.1%	−16.8%	
July, 1988	28.3%	11.1%	9.2%	12.2%	7.2%	0.9470	−0.4%	−1.4%	0.0%	0.7%	52.8%	−7.6%	
July, 1989	28.5%	15.5%	17.6%	22.5%	2.0%	0.9254	−0.3%	1.5%	0.0%	0.7%	96.3%	6.7%	
July, 1990	39.1%	29.4%	12.8%	13.5%	21.4%	0.9478	−0.4%	−0.7%	0.0%	0.4%	173.1%	38.1%	
July, 1991	25.1%	15.3%	23.4%	20.9%	5.8%	0.9012	0.3%	4.1%	0.0%	−4.2%	241.6%	59.2%	
July, 1992	18.4%	15.6%	20.5%	13.1%	5.4%	0.9500	−0.4%	4.1% *	0.0%	−0.3%	304.5%	84.1%	
July, 1993	18.7%	14.4%	12.0%	17.1%	1.0%	1.0010	−0.3%	−1.0% *	0.0%	0.0%	380.1%	110.6%	

* Includes OSHA assessment of 1.25%

Table 50

LARGE DEDUCTIBLE APPROVALS FOR 1992

Company (or Companies)	Date of Approval
Aetna Casualty and Surety Company	12/18/92
American National Fire Insurance Company	12/29/92
CNA Insurance Companies	10/29/92
Fairmont Insurance Company	12/29/92
Fireman's Fund Insurance Companies	10/9/93
Home Insurance Companies	6/1/92
Indemnity Insurance Company	10/8/92
Insurance Company of North America	10/8/92
Kemper Insurance Companies	12/21/92
Legion Insurance Company	3/27/92
Old Republic Insurance Company	9/8/92
Pacific Employers Insurance Company	10/8/92
Planet Insurance Company	12/29/92
PMA Group	2/25/92
Protective Insurance Company	10/22/92
Reliance National Insurance Company	12/29/92
Royal Insurance Group	8/21/92
Utica Mutual Insurance Company	11/25/92
Utilities Mutual Insurance Company	8/28/92
Zurich–American Group	3/2/92

Table 51

WORKERS' COMPENSATION DIVIDEND PLANS APPROVED IN 1992

PLAN TYPES:
A = Flat
B = Sliding Scale/Loss Ratio
C = Safety Group
D = Retention
E = Other

COMPANY	PLAN TYPE	FILING DATE	EFFECTIVE DATE
American Economy Ins. Co.	B	6/18/92	2/1/92
American Hardware Mutual Ins. Co.	B	7/30/92	9/10/92
American States Insurance Company	A,B	6/24/91	4/7/92
Fireman's Ins. Co. of Washington D.C.	C	2/19/92	3/9/92
Florists' Mutual Insurance Company	E*	3/16/92	7/10/92
Graphic Arts Mutual Ins. Co.	B	4/8/92	7/1/92
Insurance Company of Evanston	C	4/24/92	6/1/92
Public Service Mutual Ins. Co.	B	12/21/92	2/1/93
Republic–Franklin Insurance Company	B	4/29/92	7/1/92
Selective Way Insurance Company	B	3/6/92	9/1/92
Trans Pacific Insurance Company	B,D	3/25/92	10/14/92
Utica Mutual Insurance Company	B	4/8/92	7/1/92

* Florists' Mutual Insurance Company filed to put a cap on dividends.

4. Property/Casualty Insurance Security Fund Net Value and Contributions

Pursuant to Article 76 of the New York State Insurance Law, the Superintendent is required to annually determine the net value of the Property/Casualty Insurance Security Fund (P/CISF) and any necessary P/CISF contributions. To this end, there exists a Security Fund Task Force, consisting of members from many Bureaus in the Insurance Department, which formulates guidelines for calculating both the P/CISF net value and quarterly contribution amounts. In order for the Superintendent to have the necessary flexibility to carry out the statutory obligations concerning the P/CISF and the dynamic insurance market in general, the Task Force periodically reviews and revises the P/CISF guidelines as circumstances warrant. A subgroup of this Task Force, consisting primarily of members from the Casualty Actuarial Bureau, annually calculates the P/CISF net value and any necessary quarterly contribution amounts.

No contributions to the P/CISF were required from 1973 to 1988. In 1988, contributions resumed as a consequence of the Superintendent's determination that the P/CISF net value as of December 31, 1987 had fallen below the statutory minimum of $150 million. By statute, the quarterly contributions for the 1988 fund year were due on May 15, 1988, August 15, 1988, November 15, 1988 and February 15, 1989. Similarly, contributions have continued till 1992 as a result of the Superintendent's determination that the P/CISF net value was less than $150 million for each fund year from 1988 up to and including 1992.

Following are the estimated P/CISF contributions per quarter since the 1988 fund year. The variation from year to year in the magnitude of the estimated quarterly contributions reflects, in part, the variability associated with the P/CISF payouts for awards and expenses and the P/CISF dividends (returns from estates in liquidation) over the years.

Fund Year	Estimated Quarterly Contributions
$15.0 million	1988
$37.5 million	1989
$ 5.5 million	1990
$25.0 million	1991
$ 7.5 million	1992

During 1992 the State was in settlement negotiations with respect to Alliance of American Insurers, et al. v. Chu, et al. (Albany County, Index No. 3279/88). The net value and contribution amounts described herein do not reflect any impact from this case.

F. POLICY AND PLANNING BUREAU

The Policy and Planning Bureau was involved in several major issues during 1992, including the following:

1. Medical Malpractice

The favorable medical malpractice insurance experience of recent years appears to have leveled off. Recent increases in the frequency of lawsuits against physicians, together with continued increases in the dollar amount of medical malpractice awards (severity of claims) and a decline in interest rates which has limited insurers' investment income, have halted the positive experience of the past few years.

Legislation was enacted in 1991, that extended the statutory prohibition, until June 30, 1993, against the Superintendent's seeking an order for the rehabilitation or liquidation of a domestic medical malpractice insurer solely because of insolvency. This legislation also continued to give the Superintendent, in accordance with legislation originally enacted in 1986, the responsibility, until June 30, 1993, for the establishment of medical malpractice rates.

The Superintendent announced in July 1992, that most of New York State's 25,000 individually insured physicians would see no change in their primary medical malpractice insurance rates for the July 1, 1992 through June 30, 1993 policy year. This followed two years of average rate decreases of 5% for most physicians. However, the Superintendent also indicated that physicians with some insurers, in certain classifications and territories, would receive premium increases.

Beginning in 1985, the Legislature required hospitals, when requested by their attending physicians, to obtain and pay for an additional $1 million/$3 million layer of coverage for those who had purchased their primary coverage through an authorized insurer. Experience for this excess layer of coverage has been more favorable than experience for the primary coverage. Rates for this excess layer, for the policy year beginning July 1, 1992 through June 30, 1993, were reduced by an average of 10%. Since 1988, excess layer rates have been reduced more than 40%. This rate decrease will result in savings to hospitals and insurance companies such as Blue Cross/Blue Shield plans and private health insurers who ultimately pay for the cost of this coverage.

Since 1986, payments required for the purchase of excess coverage have been made to the hospital excess liability pool, which then purchased the excess coverage. As indicated in last year's report, the Superintendent in 1991 directed that $210 million be returned to the hospital excess liability pool by the insurers of the statutory excess coverage: $155 million from the Medical Malpractice Insurance Association (MMIA), $42 million from Hospital Association of New York State (HANYS) Insurance Company, and $13 million from HANYS Trust. These amounts were paid to the hospital excess liability pool by February 1992.

Lawsuits were brought by medical and hospital expense indemnity insurers (including all the Blue Cross and Blue Shield plans and the HMOs), which contended that these insurers were entitled to their proportionate share of the $210 million transferred.

Chapter 55 of the Laws of 1992 directed MMIA to transfer to the State's General Fund $60 million from its excess medical malpractice insurance premiums. This transfer was accomplished in September 1992. The Superintendent authorized the transfer based on an examination by an independent consulting actuarial firm of MMIA's excess medical malpractice experience and the surplus derived from such excess policies. The actuarial report concluded that MMIA would retain sufficient surplus after the $60 million transfer.

Chapter 1 of the Laws of 1993 required MMIA to transfer to the State's General Fund an additional $150 million of surplus derived from its writings of excess medical malpractice insurance policies. An independent actuarial review of MMIA determined that the transfer would not have adverse consequences on MMIA. This transfer, accomplished on February 1, 1993, was used to settle the lawsuit brought by the medical and hospital expense indemnity insurers described above.

Under the agreement, Empire Blue Cross/Blue Shield received $100 million (of the $150 million) to mitigate the impact of the January 1, 1993 rate increase on its community-rated subscribers. The law requires that the State return the $150 million (and the $60 million transferred earlier, plus accrued interest) if and to the extent it is needed to bring MMIA into compliance with the surplus requirements of the New York Insurance Law.

2. NAIC Accreditation Program

The safety and soundness of insurance companies operating in the United States is a prime objective of state insurance regulators. In many respects, each state depends to a great extent on the domiciliary insurance departments to monitor and regulate its non-domestic licensees. To assure that this interstate dependent system will work, an effective financial surveillance and regulatory structure is necessary in each state.

While the NAIC has historically worked to assist the individual state insurance departments by fostering uniformity and sound regulation through various model laws, regulations and standardized financial reporting formats, a comprehensive pronouncement on all functions and procedures necessary for effective financial regulation was not made until 1989. That year, the NAIC created a Committee on Financial Regulation Standards to establish minimum standards for the regulation of the financial solidity of insurers.

In 1990, these standards were incorporated into an accreditation process whose objectives are to:

- create a national minimum standard for financial regulation that will improve and strengthen the state regulatory system of insurance and the soundness of insurance companies;

- strengthen the ability of state insurance departments to meet the prescribed standards through self-evaluation and improvement;

- demonstrate to, and obtain from, state administrations and legislative bodies the support and resources needed to maintain an effective system of financial surveillance and regulation; and

- improve the efficiency of state regulation by harmonizing requirements, thereby eliminating duplication of procedures and unnecessary state-by-state variations.

In November 1990, the NAIC conducted an audit of the New York Insurance Department's financial regulatory capability and concluded that New York had the laws, regulations, procedures, staff and expertise to adequately monitor the solvency of its licensees. As a result, New York and Florida, which was also audited in 1990, became the first two states to receive accreditation by the NAIC. As of December 1992, the NAIC Accreditation Program has accredited a total of 18 states.

Accreditation is granted for a five-year period, but is subject to a detailed annual review to verify continuing compliance with the standards. The NAIC standards are being continually reevaluated and new requirements are added as their need is demonstrated. States are given two years to adopt the revisions in order to maintain their accreditation status.

Three new model laws were added to the original standards, which states had to enact by December 1992 in order to retain accreditation and which thereafter must be in effect in all newly accredited states. The Department has urged that these model laws be enacted during the 1993 Legislative Session.

3. International Activities

The Department remains active in international activities involving insurance.

- In 1992, the Department continued its involvement in the General Agreement on Tariffs and Trade (GATT) negotiations, both directly and through the International Insurance Relations Task Force of the NAIC (of which New York is the vice-chair). GATT is an international trade agreement among 108 countries, which currently covers only trade of goods. The United States, with an enormous service industry, has been attempting for the past six years to expand GATT to cover trade in services, which would include trade in financial services.

As of March 1993, negotiations were on hold, pending passage of new fast-track legislation that the new Clinton administration has indicated it intends to pursue in order to empower it to continue this effort. The U.S. negotiators have no expertise in insurance and are therefore relying on state insurance departments, the NAIC and the insurance industry to analyze the contents of the financial services agreement insofar as it affects insurance.

Although the insurance industry is regulated by the individual states, GATT may pre-empt some individual state laws to the extent that the state regulatory structure is viewed as denying national treatment to foreign competitors. However, when state laws are supportable for prudential reasons, they will prevail. (Prudential reasons refer to rules established to assure the financial viability of insurers.) The process permits each member of GATT (at last count 108 countries) to take "reservations" that will permit continued enforcement of such laws. The United States negotiators are relying on state regulators to develop a list of supportable reservations and to comment on those requested by other member countries.

- The European Community (EC-92) continues to progress toward a single insurance market. The final insurance directives are now being implemented by the Community, with anticipated completion by 1995. We continue to monitor the changes evolving in Europe as a result of the movement towards a single license. The European Community negotiates as a block at the GATT and, with respect to trade in financial services, is attempting to impose on GATT the single license approach embodied in the directives.

- During 1992, the Department hosted representatives from several Eastern European and Asian countries interested in modernizing their insurance markets in anticipation of rapidly expanding economies that will greatly increase the demand for insurance.

- During 1992 the trilateral trade negotiations with Canada and Mexico were successfully completed (resulting in the North American Free Trade Agreement, or NAFTA). New York, for the past three years, has been a member of an NAIC Working Group assisting the U.S. Department of Commerce negotiators in their attempts to open Mexican insurance markets to U.S. insurers. The final step before NAFTA can go into effect involves the drafting of implementing legislation. Because much of the language in the agreement is ambiguous, state insurance regulators will need to closely monitor this process.

- The Department currently co-chairs, along with the New York State Department of Economic Development, a working group of the Global New York Subcabinet on State Regulation and International Trade Policy, whose mission is to stimulate foreign interest and investment in New York State.

4. Current Issues Seminars

The Policy and Planning Bureau continues to coordinate the Department's in-house seminars on current issues. In February 1992, the first seminar was held, and addressed some of the policy issues surrounding health insurance. In June, the subject was "Policy Issues in Tort Liability" and provided an objective overview of what is occurring in the world of tort litigation. The third seminar, held in December, was titled "Perspectives on Long Term Care Insurance", and was conducted by a panel representing the Department of Social Services' Division of Health and Long-Term Care, the insurance industry, and the Insurance Department.

The seminars are attended by over 100 Department employees, and are video taped to be loaned to individuals or groups unable to attend. Seminars planned for 1993 will center on current insurance regulatory concerns such as risk-based capital, the NAIC accreditation program and national health insurance.

G. CONSUMER SERVICES BUREAU

The Consumer Services Bureau closed a total of 44,893 cases in 1992. Of these, 31,475 involved loss settlements or policy provisions of which 45% were automobile complaints, 34% were accident and health complaints, 13% were property and liability complaints and 7% were life and annuity complaints. Another 8,050 cases involved complaints against agents, brokers and adjusters. Written inquiries accounted for 2,909 cases and referrals accounted for an additional 2,459 cases. All told, the Bureau received 43,565 cases during 1992. In addition, the Bureau responded to well over 200,000 telephone inquiries.

The Bureau initiated 133 disciplinary proceedings against agents and brokers during 1992. As a result of the hearings that were concluded, the licenses of 45 brokers and/or agents were revoked with another 13 being fined $26,760. An additional 231 producers were fined $271,545 by stipulation.

As a result of the several days storm which began December 11, 1992 and caused severe flood damage throughout coastal areas in New York State, the Bureau provided the following disaster related assistance:

1. Bureau insurance examiners were allocated to staff the Governor's toll-free hotline at the State Emergency Disaster Office Headquarters in Albany on a 24-hour basis.

2. The Bureau's toll-free line was rerouted for the 516 area code to allow greater phone access to the Department.

3. Bureau insurance examiners attended town hall meetings, such as the one held by Senator Guy Velella in the Bronx on the evening of December 18, 1992 to respond to insurance related storm questions.

4. Bureau insurance examiners were allocated to staff nine Disaster Assistance Centers set up by the Federal Emergency Management Agency (FEMA). The examiners responded to storm-related insurance inquiries and assisted consumers with their insurance claims.

5. The Bureau contacted the major property and casualty insurers and obtained initial estimates of losses that were used by the State Emergency Management Office (SEMO) and federal agencies to help support the request for the Presidential Proclamation designating New York State as a federal disaster area.

6. Bureau examiners spoke on local news broadcasts concerning storm insurance coverage and assistance.

In response to a call for assistance from the Florida Insurance Commissioner, the Bureau sent an insurance examiner to work out of the Tallahassee office of the Florida Insurance Department for a week. The examiner responded to inquiries and assisted in processing complaints in the aftermath of Hurricane Andrew.

The Bureau began investigating brokers who persistently quote auto insurance premiums below the true rate, a practice termed lowballing, in order to consummate an insurance sale. By comparing the application premium quotes and deposits to the rates listed in the rating manual of the New York Automobile Insurance Plan, the Department has been able to identify those brokers that have engaged in this practice. Many brokers identified in this investigation as chronically misquoting premiums have entered into stipulations and fines.

The Bureau has entered into a joint undertaking with the Department of Social Services to participate in a Robert Wood Johnson Foundation Grant Project. This grant is intended to promote both public and private long-term care issues. The program was authorized by the Governor and the State Legislature in 1989 and by the federal government in February 1992. The Bureau will staff a dedicated toll-free number and furnish information and advice to the public. The goals of the project are to provide a more rational approach to long-term care financing that encourages self-sufficiency by guaranteeing asset protection and also the saving of State Medicaid funds. In its first three months of operation, the last quarter of 1992, the toll-free line assisted over 800 consumers, agents and other professionals involved in long-term care services to seniors. The Bureau responded to questions regarding the new minimum standards for these coverages as well as questions of availability and requests for written information.

The Bureau sponsored an in-house Current Issues Seminar on long-term care insurance on December 16, 1992, to examine the regulation, marketing and social service implications of this coverage. The seminar emphasized the work of the Robert Wood Johnson Foundation Grant to promote the public/private partnership on long-term care issues.

The Bureau and the State Office for the Aging (SOFA) have agreed to a Letter of Commitment regarding a federal grant application for a Statewide Health Insurance Counseling Program. The Bureau will provide SOFA with technical assistance regarding interpretation of and changes in the Insurance Law relating to Medicare supplement, long-term care and other types of health insurance for senior citizens. The Bureau will coordinate the furnishing of health insurance information available through SOFA and the Insurance Department to the general public by a statewide hotline number. The Bureau will also maintain statistics necessary to fulfill the reporting requirements of the grant.

The Bureau continued to meet with insurance company representatives to review complaints and inform insurers of ways to improve claims-handling and underwriting practices, with an emphasis on improving communications with insureds and claimants. These meetings will continue in 1993 in an effort to reduce the number of complaints the Department receives from consumers.

As part of its program of assistance to senior citizens, the Bureau provided speakers to a number of such groups throughout the State. The topics of Medicare supplement and long-term care insurance were the issues of primary concern to senior citizens especially in light of the dramatic changes in Medicare supplement policies in 1992. In addition, Bureau staff participated in educational and training seminars for social workers and senior citizen representatives in the area of Medicare supplement and long term care insurance. The Bureau routinely provides speakers to a number of organizations for information and educational purposes.

The Bureau provided examiners for the Department's information booth at the State Fair held in Syracuse from August 26 through September 8, 1992. The examiners answered consumer questions, took complaints and distributed the Department's various consumer guides and booklets. The booth was well attended and over 10,000 booklets and guides were distributed to the public.

The Department is a member of the Consumer Health Information Council. The Council's mission is to review issues such as long-term care, occupational health and safety, women and child health, and hospital and medical practices, and to make recommendations to the New York State Commissioner of Health. A Consumer Services Bureau representative sits on the Long-Term Care and Hospital and Medical Practices committees. The committees have been involved in developing educational health brochures and booklets, and physician and hospital directories for consumers and medical providers.

The Department is also a member of the Head Injury Services Coordinating Council. The Council facilitates the implementation of policies, services and standards that would create a coordinated and comprehensive system of care in New York State for persons with head injuries. A Consumer Services staff representative is on the Case Management Committee, which focuses on issues concerning case management systems and a statewide patient registry.

In 1992, there were several licensed insurers, both life and property, that were in rehabilitation or were experiencing financial stress. Poor investments and natural disaster losses contributed heavily to their problems. As a result, the Bureau received and responded to thousands of complaints and inquiries from consumers about the solvency of their insurers, the status of rehabilitation plans and the protection afforded by the life and property guaranty funds.

The concern over health insurance rate increases generated a large volume of written inquiries and calls especially in the last quarter of 1992 when the Department was reviewing the Empire Blue Cross/Blue Shield rate increase request. The Bureau received and responded to most of these concerns.

The Bureau conducted investigations into the activities of two agents that sold bogus insurance policies in the form of single premium deferred annuities. In addition to revoking the licenses of these agents, the Bureau was instrumental in negotiating a settlement with insurers that provided for the payment of both principal and interest of nearly $3 million to the victimized insureds. Bureau staff assisted the Attorney General's office with criminal prosecution of these agents. Both were convicted and are currently incarcerated.

The Bureau continued its investigation of licensees that sold health care benefits through Empire Benefit Plans, Inc., an unlicensed health insurance company. In 1992, 133 producers entered into stipulations with the Department and paid fines in the amount of $103,300.

The Bureau is a member of the New York State Consumer Protection Board's Consumer Services Committee. The committee includes representatives of federal, state and local consumer protection agencies and nonprofit organizations. The Committee meets to share program initiatives with peers in an effort to keep abreast of consumer concerns.

Table 52
CONSUMER SERVICES BUREAU CASES
INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS
CLOSED IN 1992

Line of Business	Total Processed	Upheld	Adjusted	Not Upheld	Other Action Taken[a]
Total	31,475	762	5,401	20,088	5,224
Life and Annuities, Total	2,053	63	347	1,339	304
Individual Life	1,725	50	301	1,118	256
Individual Annuity	216	12	31	149	24
Group Life & Annuity	112	1	15	72	24
Accident & Health, Total	10,822	262	2,274	6,866	1,420
Individual Accident & Health	1,014	19	166	702	127
Group Accident & Health	3,839	67	638	2,446	688
Article 43 & 44 Corps.	5,760	173	1,435	3,586	566
Medicare	91	0	6	57	28
Medigap	105	1	27	68	9
Long-Term Care	13	2	2	7	2
Auto, Total	14,220	304	1,988	9,199	2,729
Auto Liability (B.I.)	1,848	49	319	1,320	160
Auto Liability (P.D.)	5,132	100	658	3,194	1,180
Auto Physical Damage	3,537	81	424	2,441	591
Auto No-Fault	3,632	73	584	2,201	774
NYAIP Taxicab/Limo Pool	71	1	3	43	24
Other Property & Liabil., Total	4,189	119	761	2,585	724
Liability other than Auto	642	11	98	389	144
Professional Malpractice	20	0	2	12	6
Fire & Extended Coverage	109	5	17	62	25
Homeowners	1,741	33	187	1,196	325
Inland Marine/Ocean Marine	101	3	7	68	23
Workers' Compensation	1,182	55	404	604	119
Commercial Multiple Peril	332	7	38	220	67
Burglary & Theft	18	0	2	11	5
Fidelity & Surety	36	5	5	18	8
Flood	8	0	1	5	2
Miscellaneous	191	14	31	99	47

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[a] Includes 2,598 Cases that resulted in favorable resolution through mediation by the Bureau.

Table 53
CONSUMER SERVICES BUREAU CASES NOT INVOLVING LOSS SETTLEMENTS OR POLICY PROVISIONS CLOSED IN 1992

Subject of Case or Investigation	Total Processed	Fines, Revocations & Other Actions	Upheld	Not Upheld
Total	8,050	5,799	966	1,285
Misleading Advertising	52	32	10	10
Application for License	915	873	21	21
Acting without License	119	82	6	31
Aiding Unauthorized Company	289	244	8	37
Misappropriation of Premium	514	232	184	98
Issuing Bad Checks	1,107	827	189	91
Commingling	3	2	1	0
Rebating	9	4	2	3
Misrepresentation of Coverage	688	374	119	195
Excess Comp. without Contract	57	13	18	26
Twisting	280	181	18	81
Public Adjusters, Prohibited Practices	26	15	5	6
Violation of NYAIP/NYPIUA Rules	448	296	53	99
Commission Disputes	446	133	190	123
Return Premium--Producer	150	51	46	53
Other Violations of Ins. Law	402	213	52	137
Violations of Other Law	37	27	3	7
Fraudulent NYAIP Application	1,324	1,092	13	219
Incorporators and/or Directors	789	789	0	0
Discrimination/Redlining	2	0	0	2
Illegal Insurance Enterprise	51	45	4	2
Ending of Agency/Broker Acct.	61	51	4	6
Miscellaneous Complaints	142	102	13	27
Delay in Issuing Policy	3	2	1	0
Policy Status	4	2	1	1
License Status--Company	2	2	0	0
Voluntary Surrender of License	21	21	0	0
Miscellaneous	109	94	5	10

H. INSURANCE FRAUDS BUREAU

The Insurance Frauds Bureau is a law enforcement unit within the New York State Insurance Department. The Bureau is headquartered in downtown New York City with satellite offices in Albany, Buffalo and Syracuse. It was created September 1, 1981 to effectively investigate and discover insurance frauds, halt fraudulent activities and assist and receive assistance from federal and state law enforcement agencies in the prosecution of persons who are parties to insurance frauds. The Bureau operates under a sunset provision that recently was extended to January 1, 1997.

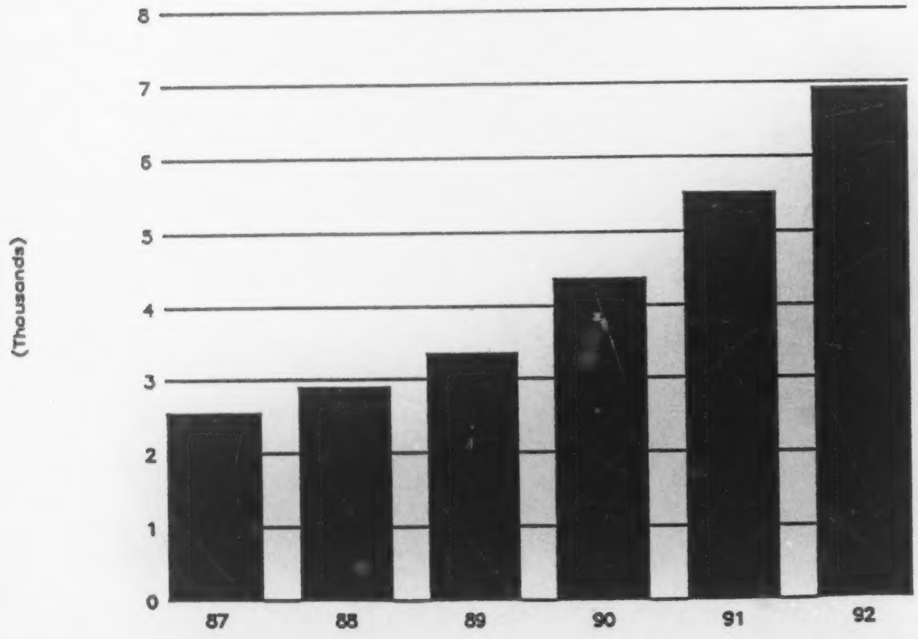
Licensees who have reason to believe that an insurance transaction may be fraudulent, or have knowledge that a fraudulent insurance transaction is about to take place or has taken place, shall within 30 days report the information on a prescribed form to the Frauds Bureau.

The number of reported frauds increased in 1992 for the sixth consecutive year. There were 6,919 reports received, a 25% increase from the prior year.

The emphasis on fraud investigations has increased commensurate with the increase in reported frauds. Carriers are devoting more funding to combatting fraud and in particular to establishing and/or expanding their special investigation units. The Frauds Bureau has continually advocated the importance of developing these specialized units and assisted several carriers in instituting such units.

Fraud Reports

1987–1992



During 1992, two pieces of legislation were signed into law that will affect the operations of the Insurance Frauds Bureau. Chapter 475 of the Laws of 1992 calls for the imposition of a civil penalty--not to exceed $1,000 for the first violation and $5,000 for each subsequent violation--for anyone who possesses or transfers a forged insurance identification card for a motor vehicle. This legislation was signed into law on July 17, 1992. Chapter 480 of the Laws of 1992 empowers the Superintendent of Insurance to levy a civil penalty, not exceeding $5,000 and the value of the subject motor vehicle or stated claim, upon any person who is found to have committed a fraudulent insurance act. This section becomes effective for policies issued or renewed on or after January 13, 1993.

Bureau personnel have conducted company briefings since 1985. These are held throughout New York State for insurance company supervisors and employees. The purpose is to inform participants of reporting requirements, the immunity statute and any laws and regulations that apply to the function of the Frauds Bureau. A total of 259 briefings with 6,369 participants has been held to date. Toward the end of the year the emphasis was on the new legislation and its impact on reporting requirements. We are expanding this program in 1993 to include law enforcement agencies. Efforts will be stepped up to emphasize the availability and importance of the new civil penalties.

In one of the Bureau's major cases in 1992, investigators went undercover as part of a "sting" operation in Suffolk County. The investigators, using fictitious names, brought vehicles with minor damage to a repair shop. When repairs were completed, the "victims" and their insurers were presented with bills that were inflated by several thousand dollars. This led to charges of three counts of insurance fraud and three counts of grand larceny. The case is now in the hands of the Suffolk County District Attorney's office.

Another sting operation in Suffolk County led to the indictment of 43 defendants on charges of illegal possession of stolen property and insurance fraud. It appears that these defendants were selling their own vehicles to the operators of the sting operation. Forty-two vehicles were recovered.

Section 7 of the Insurance Frauds Prevention Act requires that the Superintendent annually submit to the Governor and the Legislature a report on the operations of the Frauds Bureau. In accordance with this requirement, the 1992 Report was submitted on January 12, 1993.

1992 STATISTICS

I.	INVESTIGATIONS	572
II.	ARRESTS	
	Felonies	59
	Misdemeanors	7
	Total	66
III.	RESULTS*	
	Convictions	34
	Dismissals	5
	Pending	45
IV.	REPORTS RECEIVED	6,919
V.	INDEX ENTRIES	22,861
VI.	INDUSTRY BRIEFINGS	16
	Participants	1,378

*includes 1991 arrests

I. INSURANCE REGULATORY SYSTEMS BUREAU

The Insurance Regulatory Systems Bureau (Systems) provides information technology services to the Insurance Department. The Bureau has two units, one located in New York City and the other in Albany. These units support over 650 Department users. Users include actuaries, clerks, examiners, frauds investigators, real estate appraisers, lawyers, researchers and statisticians. Some of the services provided are word processing, office automation, database and spreadsheet applications, telecommunications, training and microcomputer technology support.

Volatility in the insurance industry heightened the Department's need to monitor insurer liquidity, profitability and solvency. Greater demands were made in both the private and public sectors, for more data that were both accurate and quickly accessible. During 1992, Systems kept pace with swiftly changing technologies to meet the complex, broad needs of the Insurance Department.

1. Technical Services Unit (TSU)

There are over 42 major database application systems developed and maintained on an IBM mainframe computer. Many of these applications contain hundreds of programs.

The Department recently upgraded its mainframe to an ES-9000/260. The ES-9000 series of computers was introduced in 1992. The Insurance Department installed the Model 260 at year-end. The ES-9000 mainframe series includes some of the most advanced mainframes available. It supports the Extended System Architecture (ESA) family of operating systems, required for our future strategic plans. All disk and tape peripherals were also upgraded for ESA compliancy. Systems can now install the VM/ESA operating system early in 1993. VM/ESA and the new mainframe will provide the capacity and power to meet the Department's mainframe needs for the next several years.

Two Wang VS computers, one located in New York City and one in Albany, are networked to the ES-9000. This allows data exchange between systems and access via terminals, workstations and personal computers (PCs). The VS units support over 400 PCs and terminal devices. They provide word processing, office automation and telecommunications services. During 1992, all disk and tape drives on these systems were replaced with SCSI industry-standard drives. The results were faster response time, greater storage capacity and higher reliability which supported Bureau policy to replace proprietary products with equipment and software using industry-standard technology. The operating systems and all application components were also upgraded during the year.

The Bureau also maintains a large SNA (Systems Network Architecture) connected fleet of terminals and PCs. Approximately 150 terminals and PCs are connected using SNA. This number will decline as more devices are connected with Local Area Network (LAN) technology. By the end of 1992, about 60 PCs were on the LAN.

A LAN is a method for communicating between personal computers and peripheral devices. In LAN technology, much of the processing is done within the user's PC. Only when the PC requires resources external to itself does it communicate with other devices, called servers, on the LAN. Since many PCs can share a server, a LAN is cost effective by eliminating duplication of resources on each PC. This approach, sometimes known as client/server technology, allows distributed applications to be developed using the PC and server.

There has been a technology shift toward mini- or PC/LAN-platforms due to the rapid and dramatic improvements in PC computing power, software development, LAN technology, disk storage and microchip development. These developments have had a profound effect on Systems, which has proactively met the challenge.

In preparation for the PC/LAN environment, Systems began a large scale effort to upgrade machines and operating environments. Many terminals were replaced with PCs. More than 80 PC upgrades and terminal replacements were performed. A large number of users on SNA and Wang connections have been converted to the Microsoft Windows operating environment. This is the preferred user interface for the LAN platform. In-house and vendor training was provided to educate the user community on use of these products. Several gateway and conversion products were also installed to aid the transition process. This project will continue through 1994.

Comprehensive preparations began for recabling the Insurance Department. A sophisticated fiber-optic backbone and high capacity twisted-pair cabling plant, scheduled for 1993, will enable the Department to meet all future network and telecommunications needs. The new cabling system will also help phase in LAN network technologies.

Systems is ensuring that the Insurance Department is positioned to take advantage of the opportunities available from advancements in network, telecommunications and PC/LAN technologies.

External network expansion also continued. The New York State Insurance Department was one of the first state agencies to participate in the highly successful EmpireNet data communications network. EmpireNet completed its first year of full-capacity operation in 1992. To an already extensive list, Systems added communications links to access the National Insurance Crime Bureau, the Office of the State Comptroller and VINGuard Systems.

The Systems Bureau also began work on the Department's first integrated OCR and imaging projects for the Office of General Counsel and the Health and Life Policy Bureau.

The use of portable computers grew dramatically, including notepad computers for field examiners. Fifty-five notepads were distributed to field personnel, bringing the total to over 100 units. User feedback from the previous distribution project was analyzed. Many changes and updates to the software and hardware were made. MS Word, Lotus 2.4 and the Easytrieve auditing package were loaded on all machines. New communications software and facilities were added, allowing remote users access to the Department's mainframe databases, its electronic mail system and the NAIC's applications. Disk capacity on the older machines was doubled to handle the new software products and user needs. In-house training on the new equipment and communications software was given to all laptop and notepad users. Training on MS Word was provided through a vendor.

The 1990 Omnibus Budget Reconciliation Act (OBRA) requires states to report complaints about Medicare supplement insurance to the Health Care Financing Administration (HCFA). In preparation for 1993 compliance, Systems provided the Consumer Services Bureau with PC equipment, training and NAIC CDS/PC software. The software was created to help states easily comply with the new requirements. During 1993, the in-house Consumer Services Complaint Tracking System will be modified to capture the required data. It can then be sent electronically to the NAIC, further simplifying compliance.

Lotus OneSource, a new product utilizing CD-ROM technology, the NAIC's databases and Lotus, was introduced to the insurance industry during 1992. New York was one of the first insurance departments to install and provide training for this product. Systems arranged vendor and NAIC training sessions for Department personnel. The product is used as an additional tool for manipulating annual statement data. A LAN version will allow us to offer it to many more users in 1993. This product is now supported and used by Systems' Financial Information Services staff.

2. Financial Information Services Unit

a. Annual Statement Filings

In 1992, all annual and quarterly statement filings of life and property insurers were required to be filed on diskette. By the third week in March, over 900 property and life company diskettes were uploaded by Systems' Production Control/Annual Statement Processing Unit. Data was then available on the financial database. Such timely capture of financial data is crucial to the Department's regulatory effort. Reports and manipulation of downloaded data using the Annual Statement Query Tool facilities helped all bureaus in the audit, analysis and summarization of annual statement data. Along with specific user bureau application systems, it also provided most of the statistics used in this Annual Report.

b. Help Desk

Due to the expansion of products and services provided, there were many more inquiries and trouble calls than in previous years. The Help Desk function was expanded accordingly. It responded to over 1,400 calls, an increase of 25% from last year.

c. Financial (Accounting) Information System Unit

A long-range project within Systems and the Taxes and Accounts unit is the installation, implementation and maintenance of a fully integrated financial information system. As of year-end, the manual general ledger system of the Taxes and Accounts unit had been replaced by an on-line general ledger system. The project acronym is TABS, for the Taxes and Accounts Bureau System. It provides ad-hoc query and reporting facilities.

By year-end, most accounts receivable were also being handled through the automated system which required rewriting many mainframe systems and personal computer/automated worksheet programs to provide data to the automated accounting system. The Retaliatory Tax system will be the last accounts receivable program to be automated. Because of the complex changes mandated by the Legislature, completion of this program is not expected until April, 1993.

The final phase of this project will be the incorporation of the Budget, Accounts Payable, Travel and Purchase Order modules. If funded, this project phase will begin in mid-1993, to be completed by year-end. The system will then contain all components of a fully integrated financial system, providing budgeting capabilities.

3. NAIC Involvement

a. Task Force/Working Group Participation

The Systems Bureau continued to represent the Department on various NAIC task forces and working groups. New York was a member of:

- the Audit Software Working Group of the Examination Oversight (EX4) Task Force;

- the Data/Systems Management (EX4) Task Force and the following working groups thereunder;

- the Systems Strategic Planning Working Group (determining the best short- and long-term plans for the architecture of the NAIC/State interface); and

- the Interactive Filing (EX4) Working Group (exploring ways to improve the transmittal of data among the industry, the NAIC and the regulators).

New York was Chair of the following working groups under the Data/Systems Management's (EX4) Task Force:

- the Data Capture Working Group (responsible for diskette specifications and crosschecks for the annual statement project and various other data collection initiatives);

- the filing Performance Working Group (presently developing objective criteria to evaluate the quality of an insurer's filing with the goal of improving the timeliness, accuracy and completeness of filings); and

- the Group Code (EX4) Working Group (defining the group code to facilitate consistency in database usage).

We participated in the Commercial Lines (D) - Property and Casualty Insurance Committee's Filing Submissions Working Group seeking ways to expedite and facilitate the transfer of filings and correspondence among industry and regulators.

Systems prepared and presented several proposals to the Blanks (EX4) Task Force and served on its Annual Statement Instructions Working Group.

b. NAIC Complaints Database System (CDS)
(See Applications Programming and Systems Analysis)

c. OBRA 90 Complaint Reporting Requirements - NAIC CDS/PC
(See Technical Services Unit (TSU)

d. See Training

e. Market Conduct

Meetings were arranged with the NAIC Market Conduct Affairs Manager and Property/Casualty Bureau personnel to discuss the NAIC's new market conduct initiatives, future database products and bureau training needs.

4. Applications Programming and Analysis Unit

Systems' Applications section performed system maintenance, enhancement and development activities on approximately 42 mainframe computer application systems and several personal computer application systems during 1992.

The NAIC's Complaint Database System (CDS) was brought on line in October 1991. The NAIC and Systems wanted to populate the CDS with data from New York's Consumer Services Complaint Tracking System. First, a technical review was needed to establish compliance with the requirements and complaint record data elements of the standard CDS reporting format. Next, with the Consumer Services Bureau's cooperation, the Tracking System was expanded. By year-end, New York was able to provide a test tape of complaint data for conversion to the CDS. Population of the nationwide CDS with New York's complaint data should be completed by early 1993.

New initiatives and major modifications were completed in several application areas, incorporating changes in the New York State Insurance Laws, Rules and Regulations. Other changes resulted from updated business procedures or the need to eliminate inefficient and/or duplicate procedures. Manual tasks were automated and system performance for all applications was improved or maintained.

The Corporate Affairs database system was updated several times. It now includes information required for Sections 1314 and 1316 of the New York State Insurance Law. It provides additional Regulation 109 information and workers' compensation accounts. This additional information is used for new reporting procedures.

The Health and Life Rate Control System was updated to include codes mandated by the community rating legislation. Taxes and Accounts Fire Tax Distribution files were enlarged to include filings from 100 foreign stock insurers. This information was previously submitted to the ISO Commercial Risk Services Corporation.

Several programmer/analysts worked on the implementation of the Taxes and Accounts Bureau Integrated Financial System (TABS). This development work eliminated mainframe and PC applications, consolidating them in TABS. Some of these applications were the 9108 Fire Fees, Property and Casualty Fund, 332 Assessments, Public Motor Vehicle Fund, Examiner Billing and Workers' Compensation Security Fund. The Property and Casualty No-Fault System was rewritten to send financial data automatically to TABS.

Modification of Section 403 of the Insurance Law requires the Frauds' Investigation System to provide a facility for civil penalties. This is under development. The Property and Casualty Interactive Filing, Inquiry and Complaint (PACIFIC) System was substantially modified to accommodate a revision to Form 129-B, "Report of Changes in Rates, Prospective Loss Costs and Rating Rules" and Form 129-C, "Rate Submissions." Search and report generator facilities were added to the Personnel System.

The legislatively mandated Health Insurers Complaint Ratio Report was generated from the Consumer Services Bureau database.

The Licensing System was modified and is under comprehensive review for changes mandated by recent legislation. It will accommodate requirements for agent/broker continuing-education requirements, Section 2129 compliance and satellite offices. The system was rewritten to issue licenses to reinsurance brokers and managers, thus satisfying the NAIC's accreditation requirements.

Enhancements were made to the Systems Bureau's internal Project Management System and the Office of General Counsel's Litigation System.

The Mailing System was regularly updated, accommodating various Insurance Department information mailings. Extensive changes were also made to allow the system to interact with TABS.

5. Training

a. Systems Information Seminar

About 100 members of the Insurance Department, most of them examiners, attended the first Systems' seminar. The topic was contemporary computer auditing. The panelists were an audit specialist from the Texas Insurance Department, a Life Insurance and Companies Bureau field examiner and a representative from Coopers and Lybrand. Systems will continue the information seminars in 1993.

b. Lotus 1-2-3 Training

In addition to individually booked training sessions, Systems and Personnel provided vendor Lotus training classes for over 130 Department employees. The project took place in both Albany and NYC and provided training at all skill levels. If funding is available, Systems will provide continued vendor training in 1993.

c. NAIC On-Site Training

- Lotus OneSource

Nineteen New York State Insurance Department staff members received hands-on, intensive training in Lotus OneSource. This product was jointly produced by the NAIC and Lotus Development Corporation. (See Item 1, Technical Services Unit.)

- Easytrieve Plus

We arranged for the NAIC to present introductory training sessions on the use of Easytrieve software. The hands-on training class was given to 18 examiners. Easytrieve is the standardized audit software package that has been mandated for use on Zone examinations and is the Department's standard audit package.

d. PRO-JECT Software System

The Life Insurance and Companies Bureau real estate appraisers attended seminars on using PRO-JECT software. At their request, Systems researched and then purchased the product. It is an industry standard for computerized real estate analysis and is a valuable solvency surveillance tool. The training maximized the effective use of the software.

e. TABS

On-site vendor courses were conducted for users of the automated general ledger system. In addition, Reportbuilder classes were provided to Systems staff.

f. MS Word

MS Word vendor courses were provided for portable computer users.

g. Windows

In-house training was provided for all Windows environment users.

h. Portable Computers

In-house training was given on the new hardware and new communications facilities.

J. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION

The Motor Vehicle Accident Indemnification Corporation (MVAIC) was originally created to provide compensation for injuries to persons who, without fault on their part, were involved in accidents caused by hit-and-run drivers, operators of stolen vehicles or uninsured motorists. This law became effective on January 1, 1959. The tort law has since been amended so that comparative negligence is now the law of the State of New York. In that respect, MVAIC's obligations to provide compensation have been changed.

Chapter 665 of the Laws of 1979 increased the Corporation's coverage in death actions from the former $10,000/$20,000 limits to $50,000/$100,000 limits. The bodily injury coverage of $10,000/$20,000 remains unchanged. This law become effective December 1, 1979. Assessments covering the cost of MVAIC administration and claims are levied against all insurers licensed to write motor vehicle liability insurance in New York State in proportion to each insurers's share of net auto liability premiums in the State.

During 1992, MVAIC opened 5,105 new files. A total of 2,271 cases were settled with payment in 1992 at an average cost per claim of $9,072. In 1990 and 1991, the average settlement per claim was $8,512 and $9,002, respectively. An additional 1,208 cases were closed without payment for various reasons, including the discovery of applicable automobile insurance, the abandonment of claims and findings that MVAIC was not liable. The number of pending claims at the close of 1992 was 10,911, an increase of 1,884 from the prior year.

Qualified claimants (persons who are residents of the State of New York or of another state that has a similar program, and who do not own automobiles or are not resident relatives of a household where there is an insured vehicle) receive maximum benefits under the No-Fault Law. Legislation enacted in 1965 provided that insured cases would be processed and covered by the insurance company that had issued the Uninsured Motorists Endorsement on policies as of July 1, 1965. The insured cases have now phased out completely.

As a result of the enactment of Section 5221 of the Insurance Law effective December 1, 1977, the Corporation also became involved in the payment of no-fault, first-party benefits as of the date. It should be noted that the Corporation must provide for the payment of such first-party benefits only to qualified persons who have complied with all the applicable requirements of Article 52 of the Insurance Law. Amendment 19 to Regulation 68, effective September 1, 1985, permits MVAIC to arbitrate no-fault cases against carriers that have not signed the Inter-Company Arbitration Agreement, thus eliminating the necessity of commencing Declaratory Judgment Actions in unresolved coverage questions. It is estimated that this Amendment will save the Corporation approximately $300,000 in legal fees yearly.

The law provided that the Board of Directors submit a Plan of Operation to the Superintendent of Insurance for approval no later than October 1, 1977. The Plan was filed and approved. The Plan of Operation has since been revised. The new Plan was approved by the New York State Insurance Department and became effective July 18, 1989.

Effective November 13, 1991, the No-Fault Law was amended to increase the maximum monthly loss earnings from $1,000 to $2,000. This will definitely have an impact on the yearly no-fault payments.

Effective January 1, 1982, Section 5221(b) 2 and 4 of the Insurance Law was amended so that qualified persons who are in compliance with the requirements are deemed to be covered persons. No payment for noneconomic loss shall be made to covered persons unless such persons have incurred a serious injury as defined by Section 510(d) of the Insurance Law.

The Corporation is funded through levies on insurance companies transacting automobile liability insurance in the State of New York in accordance with Section 5207 of the Insurance Law.

Other sources of funds include fees collected from self-insurers by the New York State Department of Motor Vehicles under Section 316 and Section 370-4 of the Vehicle and Traffic Law, as well as investment income and subrogation recoveries.

TABLE 54
SOURCE OF FUNDS
Motor Vehicle Accident Indemnification Corporation
1990-1992

Source	1992	1991	1990
Net assessments	$30,500,000	$30,000,000	$18,000,000
Self-insurers' fees	109,535	109,148	107,244
Investment income	3,819,408	3,739,064	3,580,794
Subrogation recoveries	2,360,228	2,137,916	1,922,108
TOTAL	$36,789,171	$35,986,128	$23,610,146

Table 55
TRANSACTIONS
Motor Vehicle Accident Indemnification Corporation
1990-1992

Transaction	1992	1991	1990
		Number of Cases	
Pending at beginning of year	9,027	7,113	6,833
Total opened cases	5,363	6,355	4,094
Reported qualified	-0-	-0-	-0-
Reported tort and no-fault[a]	5,105	6,129	3,779
Reopened[a]	258	226	315
Total closed cases[a]	3,479	4,441	3,814
Cases closed without payment	1,208	1,846	1,687
Settled cases with payment	2,271	2,595	2,127
Qualified persons	1	-0-	1
No-fault and tort	2,270	2,595	2,126
Pending at end of year[a]	10,911	9,027	7,113
		Payments of Settled Claims	
Payments to claimants	$24,498,424	$24,591,556	$20,481,294
Qualified persons	4,500	-0-	1,000
No-fault tort	$24,493,924	24,591,556	20,480,294
Allocated claims expense[b]	3,119,615	2,639,361	2,366,034
		Reserves Year End (in 000s)	
Total reserves[c]	$51,483	$46,825	$44,503
On pending claims	34,150	33,230	32,509
On claims (IBNR)	14,052	10,586	9,124
Special expense reserve	2,940	2,677	2,498
On unallocated claim expense	341	332	372

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[a] Most claims count as one case for BI or tort and one case for no-fault PIP.

[b] The Corporation also expended $3,106,843 in 1992, $3,062,033 in 1991 and $2,709,777 in 1990 for operations and maintenance (unallocated expenses).

[c] Surplus was $2,290,747 at year-end 1992, $608,372 at year-end 1991 and ($2,830,046) at year-end 1990.

Source: Motor Vehicle Accident Indemnification Corporation

The following table distributes, by type of case, the 5,105 claims newly reported during 1992. The uninsured New York automobile driver represents 62.41% of the total reported cases compared with 58.96% for the previous year, an increase of 3.45 percentage points.

Table 56
NEWLY REPORTED CASES BY TYPE
Motor Vehicle Accident Indemnification Corporation
1992

Types of Case[a]	Number of Claimants	Percent of Total
Total qualified,[b] no-fault PIP	5,105	100.00%
Uninsured out-of-state automobiles	220	4.31
Uninsured hit-and-run drivers	1,582	30.99
Uninsured New York automobiles	3,186	62.41
Stolen automobiles	51	1.00
Automobiles operated without consent of owners	-0-	0.00
Insured automobiles where the insurance is inapplicable to the accident	14	0.27
Unregistered automobiles	52	1.02

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[a] This classification of case by type is made at the time claim is received. On subsequent investigation, a large portion of these cases is closed without payment while others are reclassified because the initial determination was not supported by the facts.

[b] The Status of Limitations on qualified cases has now run; consequently no such cases were reported in 1992. However, payments to claimants from previously reported cases continued. As of December 1, 1977, MVAIC has been involved in no-fault. When both tort and PIP are involved, a separate claim count is established for each.

Source: Motor Vehicle Accident Indemnification Corporation

The following table distributes, by type of case, those cases settled with payment in 1992 and the amount paid. Unidentified hit-and-run drivers, while representing only 42.80% of all cases, accounted for 47.43% of the total amount paid. This is attributable to the large proportion of these cases involving pedestrians in which the incidents of severe injuries and fatalities is relatively high.

Table 57
SETTLED CASES WITH PAYMENT BY TYPE
Motor Vehicle Accident Indemnification Corporation
1992

(dollar amounts in thousands)

Type of Case	Number of Claimants	Percent of Total	Amount Paid*	Percent of Total
Total	2,271	100.00%	$24,498	100.00%
Uninsured out-of-state autos	177	7.80	1,484	6.06
Unidentified hit/run drivers	972	42.80	11,620	47.43
Uninsured New York automobiles	1,046	46.06	10,727	43.79
Stolen automobiles	24	1.06	212	0.87
Automobiles operated without consent of the owner	1	0.04	30	0.12
Insured automobiles where the insurance is inapplicable to the accident	16	0.70	108	0.44
Unregistered automobiles	35	1.54	317	1.29

* Includes PIP partial payments. Excludes subrogation received on cases previously settled and allocated loss adjustment expense.

Source: Motor Vehicle Accident Indemnification Corporation

II. LEGISLATION ENACTED, REGULATIONS PROMULGATED AND CIRCULAR LETTERS ISSUED IN 1992

A. INSURANCE LEGISLATION ENACTED

1. Amendments to the Insurance Law

Part 1 of this summary covers 20 bills amending the Insurance Law that were enacted at the 1992 Session. Where a bill amended other laws as well, provisions of interest are noted. Part 2 of the 1992 Summary will cover amendments to laws other than the Insurance Law. These brief descriptions of the laws are intended only to provide highlights of the legislation and should under no circumstances be used in place of the full text of the law or regarded as interpretation of legislative intent or of Insurance Department policy.

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Section	Chapter	Signed	Effective	Bill	By
107(24),(33)	324	7-17-92	1-1-93, generally	S.5555-A	Sen. Velella
307(b)(1),(2)					
1102(e)(1)(A)					
1110(b)					
1110(f) New					
1301(a)(1),(9)					
1302(a)(5)					
1402					
1403					
1403(d)(6)(B)					
1403(e)(2)					
1404(a) variously amended					
1404(b)					
1405 (Heading)					
1407(a)(8)					

Section	Chapter Signed	Effective	Bill	By
1408(Heading)				
1408(a)				
1409				
1410 Repealed				
1411(h)				
1413(a),(b)(2)				
1414(b)(1)				
1414(c)(1),(2)				
1414(e)				
1601				
1604(b)				
1605(a)(2)				
1608(d)				
1609				
1610				
1611 New				
4526 New				
6405(d)				
6406(a)				
6406(b)(3),(5),(6)				
6501(g)(4)				
6502(b)(3)				
6907(a)(1)(C)				

This chapter serves a threefold purpose:

(1) to simplify the investment rules applicable to non-life insurers and afford property/casualty and co-operative property/casualty insurance companies expanded opportunities to invest in subsidiaries;

(2) to correct a technical error in Section 6907(a)(1)(C) relating to financial guaranty insurance transition provisions;

(3) to require an opinion of an independent certified public accountant relative to the annual statement of each insurer which is a party to a consolidated or combined financial statement.

The major provisions of this legislation are as follows:

Amends the present exemption for filing a certified financial statement in Section 307(b)(1) so that the exemption will only apply to certain assessment cooperative property/casualty insurers and require the submission of the financial statements of any non-life investment subsidiary and will require the certified public accountant to audit and express an opinion on any such subsidiary. Also requires an opinion of an independent certified public accountant relative to the annual statement of each insurer which is a party to a consolidated or combined financial statement.

Requires charitable annuity societies to invest their funds in accordance with the provisions of new Section 1110(f) and Section 1403(b). Limits the authority of charitable annuity societies to invest in certain investments.

Broadens the definition of "cash" to include deposits in a bank, trust company or thrift institution.

Requires all qualifying obligations of the United States to be guaranteed as to principal and interest and to exclude any qualifying investment which is not on deposit for the benefit of all policyholders or all policyholders and creditors.

Clarifies the authorization of all domestic insurers, other than life insurers, to do exchange-traded covered call options.

Permits certain subsidiaries to qualify as a reserve investment.

Clarifies the section heading to Section 1404 to make the types of prohibited investments, as set forth in Section 1407, applicable to Section 1404 reserve investments. The types of investments which will qualify as reserve investments are as follows:

1. Government obligations
2. Obligations of an American institution
3. Preferred shares of an American institution
4. Loans secured by real property
5. Real property or interests therein
6. Foreign investments
7. Development bank obligations
8. Equity interests
9. Investment made by subsidiaries
10. Investment companies - for non-life insurers
11. Leeway provision - for non-life insurer

Simplifies the provisions dealing with U.S. government obligations and preferred shares of American institutions. Amends the qualifications for obligations of American institutions to require compliance with one of the following tests:

(i) adequate collateral security,
(ii) rated A or higher by a securities rating agency,
(iii) insured by a licensed insurance company, which result in a Aaa rating, or
(iv) given the highest quality designation by the Securities Valuation Office of the NAIC.

Simplifies the investment standards applicable to loans secured by real property.

Revises the provisions dealing with investments in real property. The revised provisions will now (i) permit the acquisition of real property through an interest in a limited partnership and (ii) require the Superintendent's approval for certain major capital improvements.

Revises the provisions dealing with foreign investments. Formerly under this paragraph a non-life insurer could invest up to 10% of its admitted assets in investments in Canada and 1% in the investments of other foreign countries. With this amendment a non-life insurer, other than a fraternal benefit society or charitable annuity association, is able to invest up to 10% of admitted assets in investments of other foreign countries but the aggregate amount of securities in any one country, other than Canada, may not exceed 3% of admitted assets in the case of the country having the highest sovereign debt rating or 1% of admitted assets in the case of all other countries. Insurers subject to the provisions of Section 1403(c), (i.e., property/casualty insurers), may make additional foreign investments pursuant to the provisions of revised Section 1407(a).

Amends the provisions dealing with investments in common shares by non-life insurers, other than property/casualty insurers, by changing the paragraph heading to equity interests. The revised provisions eliminate various obsolete limitations dealing with the ownership of voting shares.

Adds two new types of reserve investments ("Investments made by subsidiaries" and "Investment companies"). An investment in real property and in loans secured by real property made by an eligible subsidiary that is exclusively engaged in the acquisition, ownership and management of such investments will be classified as a reserve investment. A non-life insurer that makes investments under the authority of Section 1404, other than a property/casualty insurer, may acquire eligible bonds, preferred shares and equity interest through an ownership in an eligible investment company.

Amends the leeway investment provisions for insurers that do not make investments under the authority of Section 1403(c) to (i) increase the amount of leeway provision investments from 4% to 5% of the insurer's admitted assets and (ii) exclude from qualifying leeway provision investments certain prohibited investments. For insurers subject to the provisions of Section 1403(c), (i.e., property/casualty insurers), a leeway provision investment is a non-reserve investment under Section 1407.

Sets forth the types of non-reserve investments that can be invested in by an insurer subject to the provisions of Section 1403(c), (i.e., property/casualty insurers), and revises the list of investments that are prohibited for such insurers. Such revisions will increase the permissible amounts of foreign and leeway provision investments. Adds a prudent-person rule that is identical to the one enacted for life insurers in 1983.

Requires the inclusion of any corporation having a majority of its assets invested in insurance companies when computing the applicable limitations in the ownership of insurance company shares. Under past law, investments in such corporations were prohibited by the provisions of Section 1407(a)(5), but this prohibition is now eliminated.

Makes certificates of deposit specifically subject to the general 10% of admitted assets limitation.

Clarifies eligibility standards for foreign investments in the trusteed surplus account of a United States branch of an alien insurer.

Clarifies the valuation of shares in an investment company. Requires any corporation having a majority of its assets invested in insurance companies to be valued as an insurance company.

Replaces the current laundry list of permissible subsidiaries of non-life insurers with broad authority to invest in any lawful business except banking. This is identical to the authority that was enacted for life insurers in 1983.

Clarifies the applicability of Section 1506 ("Acquisition or retention of control of insurer") when a domestic insurer disposes of a domestic insurance company subsidiary.

Clarifies that an insurer's subsidiary may be controlled by means other than through ownership of voting shares.

Clarifies the applicability of the provisions of Article 15 ("Holding Companies") to subsidiaries that are also persons in a holding company system.

Specifies the activities that a domestic insurer may continue to perform itself, without having to establish a separate subsidiary.

Subjects the total amount of assets owned by the insurer and its subsidiaries to the same limitations that would otherwise apply to such assets if they were held directly by the insurer. Imposes an aggregate limit on the amount of an insurer's invested assets that can be invested in subsidiaries. Excluded from such aggregate limit is an investment in a subsidiary that is an insurance company and a subsidiary that holds real property or mortgage loans.

Modifies the types of investments permitted for fraternal benefit societies.

(An Amended 1991 Department Bill)

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Section	Chapter	Signed	Effective	Bill	By
209 1109 3221(m)(1)-(4) 3231 New	501	7-17-92	Various, see chapter for details	A.12350-A	Rules

Section	Chapter Signed	Effective	Bill	By
3232 New				
3233 New				
4304 (e)(1)				
4304 (e)(4) New				
4304 (k) New				
4305 (d)(1)				
4308 (b)				
4308 (d),(e),(f)				
4309 (a)				
4317 New				
4318 New				
Public Health Law				
225 (11) New				
4406 (1)				

The purpose of this chapter is to require open enrollment and community rating of individual and small group health insurance policies by all insurers, including health maintenance organizations (HMOs); to require insurers to credit the time a person is covered under prior health insurance coverage in applying the provisions of a pre-existing condition limitation; to provide for the stabilization of health insurance markets and premium rates; to extend certain continuation rights of individuals; and to require a management audit of certain Article 43 corporations.

The major provisions of this legislation are as follows:

Requires the Superintendent of Insurance, in consultation with the Commissioner of Health, to appoint an advisory panel for the purpose of developing a standardized medical claim form. The panel shall make its report by July 1, 1993.

Conforms State law to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requirements for continuation of group medical coverage to allow individuals to continue their group health insurance benefits for a limited time.

Adds a new Section 3231 to the Insurance Law and requires that health insurance sold directly to individuals, and health insurance sold through small groups, shall be offered on an open-enrollment basis and premiums for the coverage shall be based on a community-rating methodology. This requirement includes Medicare supplement insurance for the elderly. Small groups are defined as those with 50 or fewer employees or members (not counting spouses and dependents).

Open enrollment is defined as requiring insurers to accept all persons who apply for coverage from the insurer. Community rating is defined as a method of setting premium rates in which the premium for all persons covered by that type of policy do not vary based on age, sex, health status or occupation.

Clarifies that there can be different rates for coverage sold to individuals as opposed to coverage for a family. Also confirms that an insurer can have one community rate for persons purchasing coverage directly from the insurer and a separate, different community rate for persons who obtain that same coverage through a group; specifically states that rates can vary by geographic region.

Provides for prior approval by the Superintendent of commercial insurance rates. The rates cannot be excessive, inadequate or unfairly discriminatory. After October 1, 1994, commercial insurers may elect an alternate rate approval process in which the commercial insurer guarantees that at least 75% of the premiums will be expended as claims payments to the insured persons; provides a hearing procedure that insurers can initiate in the event the Superintendent disapproves more than 20% of a rate increase request.

Provides that insurers may not sell administrative services only (claims-processing functions without insurance/risk features) to small groups or associations. Insurers are also prohibited from selling stop-loss insurance to self-insured groups or associations. However, insurers that are providing administrative services only or stop-loss type insurance to associations may continue to do so for those particular associations. Insurers may continue to serve those particular associations only if by April 1994 the group community rates and accepts additional members without underwriting, and the number of small group members in the self-insured association does not increase by more than 10% per year until the association offers open enrollment and ceases to experience rate.

Adds a new Section 3232 to require every insurer delivering an individual or small group health insurance policy in this State that contains a pre-existing condition provision, in determining whether such pre-existing condition provision applies to a covered person, to credit the time such person was covered under a prior group, group remittance or individual health insurance policy, if the prior coverage was continuous to a date not more than 60 days prior to the effective date of coverage.

Requires the Superintendent to promulgate regulations by October 1, 1992 to assure an orderly implementation of open enrollment and community rating. Prior to adopting the regulations, the Superintendent is required to convene an advisory committee to advise the Superintendent on issues such as reinsurance, pooling, risk sharing and premium stabilization methods. The Superintendent is authorized to hire an actuary to assist the advisory group.

Requires that Article 43 corporations (such as Blue Cross and Blue Shield plans) offer major medical or similar coverage to persons who are terminating their major medical type group coverage and buying individual coverage.

Authorizes the Superintendent to defer, reduce or reject premium increases for Article 43 corporations if, in the judgment of the Superintendent, salary increases for senior level management are excessive or unwarranted given the financial condition of the corporation.

Requires the Superintendent to order a management audit of an Article 43 corporation whose combined premium volume exceeds $2 billion. The audit is to be completed by May 1, 1993. The Superintendent is also authorized to require management audits of any Article 43 corporation when significant losses are sustained.

Reduces the level of permitted administrative expenses for Article 43 corporations that receive more than half of their premiums from the sale of contracts that provide hospital service benefits.

Imposes the same requirements of community rating and open enrollment on Article 43 corporations as are imposed on commercial insurers.

Requires the Public Health Council, in conjunction with the Superintendent of Insurance, to investigate the viability of wellness discounts to be applied to community-rated premiums for healthy lifestyles such as not smoking, physical fitness or dietary habits.

Amends the Public Health Law concerning health maintenance organizations. HMOs are subject to all the community rating, open enrollment and portability of coverage requirements imposed on insurers. When selling directly to individuals these contracts can include a pre-existing condition clause. As an alternative to employing a pre-existing condition limitation, an HMO may elect a waiting period of up to 60 days between the time the applicant completes the application and the time the coverage actually becomes effective.

(A Governor's Program Bill)

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Section	Chapter	Signed	Effective	Bill	By
210 New	657	7-31-92	7-31-92	S.5901	Sen. Velella

Adds a new Section 210 to the Insurance Law, entitled "Annual rating of health insurers" to require that the Superintendent annually report, on or before December 15 to the Legislature and the public, an analysis of insurers providing individual accident and health insurance or group or blanket accident and health insurance.

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Section	Chapter	Signed	Effective	Bill	By
337 New 338 New 2112(c) 3425(1)(2) 3425(m)(3) 3425(n) New 3425(o) New	647	7-24-92	7-24-92, generally	A.12361	Rules - Mr. Grannis Mr. Lafayette

Extends, from August 1, 1992 to August 1, 1996, the rules subject to which personal automobile insurance and other personal lines including homeowners policies are required to be renewed.

Adds a new Section 337 to the Insurance Law that provides for an annual consumer guide on automobile insurance to be published and made available to the public by the Superintendent no later than October 1 of each year beginning in 1993.

Adds a new Section 338 of the Insurance Law that provides for a biennial report on the Automobile Insurance Plan no later than May 1, 1994 and every two years thereafter to be furnished to the Governor and each house of the Legislature by the Superintendent.

Requires a report by the Superintendent to the Legislature by March 15, 1996 concerning Section 3425, similar to the report that was required and furnished to the Legislature on March 25, 1992.

Provides that a certificate of appointment of an insurance agent shall be valid until terminated by the appointing authority after a termination in accordance with the provisions of the agency contract.

Provides that in the event the Superintendent makes a determination that an insurer's elimination of premium installment plans, reduction in producer commissions or any other marketing action was implemented to effectuate a withdrawal or substantial withdrawal from writing automobile insurance, certain actions with regard to producer commission and consumer safeguards must be taken by that insurer.

Provides that if an insurer intends to materially reduce its volume of personal lines policies, it must report to the Superintendent, within 30 days of implementation, a description and explanation of the actions such insurer intends to take to ensure an orderly reduction and minimize market disruption.

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Section	Chapter	Signed	Effective	Bill	By
493(c) Re-lettered as (d) 403(c) New 403(e) New 2336 (Heading) 2336 (e) New 2336 (f) New	480	7-17-92	1-13-93, applies to all policies issued or renewed as of that date.	A.11748-A	Rules - Ms. Mayersohn

Executive Law
837-a(1)
837-a(5)

Requires all applications for commercial insurance and all claim forms, except automobile, to contain a statement that a civil penalty, not to exceed $5,000 and the stated value of any fraudulent claim, may be imposed on any person who knowingly and with intent to defraud any insurance company files such a fraudulent claim.

Provides for a $5,000 civil penalty that may be imposed by the Superintendent on any person, including those persons and their employees licensed by the Insurance Department, who are found to have committed a fraudulent insurance act.

Requires all applications for automobile insurance and all claims forms to contain a statement that a civil penalty, not to exceed $5,000 and the value of the subject motor vehicle or stated claim, may be imposed on any person who makes a false report of the theft, destruction or damage of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles, or an insurance company.

Provides that any rating plan for private passenger automobile insurance must contain an appropriate reduction in premium charges for comprehensive coverage for any vehicle equipped with an anti-theft electronic homing device used in conjunction with a police agency. Further provides that the nonuse of this device or any other anti-theft device shall not be grounds for a premium increase nor for cancellation or nonrenewal of the policy.

Provides that any rating plan for private passenger automobile insurance must contain an appropriate reduction in premium charges for comprehensive coverage for a vehicle equipped with window glass etched with the vehicle identification number or any other identifying symbol.

Amends the Executive Law to include the crime of insurance fraud among the data collection requirements.

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Section	Chapter	Signed	Effective	Bill	By
1404-a(6)	702	7-31-92	1-27-93	A.8620-C	Rules -
	703	7-31-92	1-27-93	A.12261	Mr. Grannis

Local Finance Law
11.00(a)(41-c) Repealed
135.00(a)(4-b) Repealed
133.00(8)(Closing¶) Repealed
143.20 Repealed
151.00(b)(2-a)
152.00(a)(3)
152.00(a)(5) Replaced
152.00(c)(1)
152.00(c)(2)
152.00(e)
152.00(g)

New York City
Admin. Code
11-243(c)(2)
11-243(c)(3)
11-243(d)(8)

Private Housing
Finance Law
654 (23-c)(3)
654(24) Renumbered
as (25)
654(24) New
654-d (New)
654-d (18)
664(3) New
667(1)
667(2) New
Article XIV - Repealed

Real Property
Tax Law
421-a
489 (2)(a)(2)
489(2)(a)(3)
489(11)(a)(1)(B)
489(11)(a)(2-a)

Laws of 1986
Chapter 32

Repeals Article XIV of the Private Housing Finance Law (the "New York City Rehabilitation Mortgage Insurance Corporation") and adds a new Section 654-d to Article XII of the Private Housing Finance Law to create a successor public benefit corporation to be known as the New York City Residential Mortgage Insurance Corporation. The new corporation possesses additional powers and is a subsidiary of the New York City Housing Development Corporation.

A chapter amendment contained in Assembly bill 12261 amends the Private Housing Finance Law, Section 654-d (18), to correct technically deficient language concerning the setting of rents.

Insurance Law Section 1404(a)(6)(O)(iii) authorized insurers to make investments in obligations secured by mortgages upon real property insured or committed to be insured pursuant to Article 14 of the Private Housing Finance Law. This chapter amends such Section to reflect the repeal of Article 14 and the addition of Section 654-d of the Private Housing Finance Law thereby allowing insurers to invest in mortgages insured by the new entity.

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Section	Chapter	Signed	Effective	Bill	By
2104(c)(1)	96	5-21-92	5-21-92	S.1671	Sen. LaValle

Amends Section 2104(c)(1) of the Insurance Law relating to the age requirement for licensure as an insurance broker. Provides that every individual applicant for a broker's license and every proposed sub-licensee shall be of the age of 18 (rather than 21) years or over at the time of the issuance of the license.

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Section	Chapter	Signed	Effective	Bill	By
2107(b)(1 2132 New	656	7-31-92	7-31-92, generally	S.4975-C	Sen. LaValle

Requires insurance licensees to take continuing education courses during each biennial licensing period from specified sources to be approved by the Superintendent, in order to renew their licenses. Those entities eligible to offer courses, programs of instruction, or seminars to fulfill the continuing education requirement must file an application for approval with the Superintendent on a biennial basis and pay a filing fee per organization, per course, and per instructor. Each licensee would pay a biennial fee of $10 to the Superintendent for the continuing education certificate filing and recording charges, in addition to their licensing renewal fee.

Increases the fees for an application for an insurance consultant's license and places these licenses on a two-year cycle, the life insurance consultant's license expiring in the odd number years, and the general insurance consultant's license expiring the even numbered years.

Appropriates $400,000 to the Insurance Department for the purpose of implementing continuing education requirements.

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Section	Chapter	Signed	Effective	Bill	By
2132 New	475	7-17-92	8-16-92	A.11634-B	Rules - Mr. Lafayette

Provides that any insurance company, insurance agent, insurance broker or other person who or that possesses or transfers a forged insurance identification card for a motor vehicle shall be liable for payment to the people of this State of a civil penalty in a sum not exceeding $1,000 for the first such violation and a sum not exceeding $5,000 for each subsequent violation.

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Section	Chapter	Signed	Effective	Bill	By
2305-a New	729	7-31-92	4-15-93	A.10364-C	Mr. Morelle, et al.

Provides that any rate change for workers' compensation insurance shall be approved by the Department no later than of July 15 of the year in which the rate change is to take effect and any such rate change shall not take effect until on or after October 1 of that same year, if submitted between April 15 and July 15. In all other cases, rate filing shall be approved by the Department not less than 75 days before the effective date of such rates filed.

Every insurer shall notify any insured affected by a rate change made by it of such change at least 30 days prior to the date of any billing for such rate change made by the insurer. Such notice shall include an estimate of the increase as well as an explanation of the nature of the increase, and cost factors associated with said increase. Any such rate shall be payable by an insured on an installment basis of not less than two payments per policy period, should the insured so choose, for any policy with a premium in excess of $1,000.

The Department shall make available to the public a list of rate changes by industry classification within 15 days from the date the Department approves any rate changes.

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Section	Chapter	Signed	Effective	Bill	By
2345	461	7-17-92	1-1-93	A.10693-A	Messrs: Bennett, Lafayette, Grannis

Expands the scope of the Section, which currently requires that rate surcharges by private passenger automobile insurers be expressed in dollar amounts. Requires disclosure of reductions as well as surcharges, provides that every authorized insurer must specify the nature and duration of each premium reduction or surcharge applied on a non-commercial motor vehicle insurance policy. Also requires that the insurer specify the total dollar amount attributable to all surcharges and the dollar amount attributable to each reduction.

The disclosures must be made on either the premium bill, the declarations page or a notice accompanying the premium bill or the declarations page, when the surcharge or reduction is initially made and thereafter at each policy renewal.

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Section	Chapter	Signed	Effective	Bill	By
3216(i)(14) New 3216(1)(14) New 3216(t) New	771	8-7-92	1-1-93, and shall apply according to its terms to all policies and contracts issued or renewed on or after such date.	S.4516-A	Sen. Hannon, et al.

Requires that every policy providing hospital, surgical or medical care coverage shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older. This annual cervical cytology screening coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent consistent with those established for other benefits in a given policy.

Provides that the annual cervical cytology screening coverage shall be included at the inception of all new policies and with respect to all other policies at any anniversary date of the policy subject to insurability.

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Section	Chapter	Signed	Effective	Bill	By
3216(c)(4)(C) 3216(i)(12) Renumbered (13) 4235(f)(2) 4303(q) Relettered (s) 4304(d)(1) 4305(c)(1)	131	6-8-92	6-8-92, generally but see the chapter for details.	A.7562-A	Ms. Mayersohn

Requires insurers and Article 43 corporations to permit the person to whom the policy is issued to elect coverage of newborn infants from the moment of birth. Provides that if notification and/or payment of an additional premium or contribution is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth. The election is not required in the case of student insurance or where the group remitting agent's plan does not provide coverage for dependent children.

Corrects technical errors in legislation already enacted. Chapter 897 of the Laws of 1990 and Chapter 853 of the Laws of 1990 both added a paragraph 12 to subsection (i) of Section 3216 of the Insurance Law and a subsection (q) to Section 4303 of the Insurance Law. The coverages added are totally unrelated to one another. Section 5 renumbers the paragraph 12 (added by Chapter 897 of the Laws of 1990) as paragraph 13. Section 6 reletters subsection (q) (also added by Chapter 897 of the Laws of 1990) as subsection (s).

Makes it clear that newborn infants are entitled to coverage under a parent's plan whether the insured parent has an individual, two person or family health insurance coverage. Newborn coverage is not required in those circumstances where it does not make sense, such as where the plan of insurance does not provide any coverage for dependent children.

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Section	Chapter	Signed	Effective	Bill	By
3216(c)(4)C) 4235(f)(2) 4304(d)(1) 4305(c)(1)	464	7-17-92	1-1-93,	A.10930-C	Mr. Flanagan, et al.

Clarifies the meaning of family coverage in individual and group health insurance policies. A newly born infant adopted by the insured, if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to the Domestic Relations Law within 30 days of birth, is included within the definition of newborn infants under family coverage.

Further provides that such newly born infants adopted by the insured will not be included within the definition of a newborn infant if notice of revocation to the adoption has been filed pursuant to the Domestic Relations Law and consent to the adoption has been revoked. Also provides that in cases of adoption, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

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Section	Chapter	Signed	Effective	Bill	By
3425(n)New Banking Law 6-k New	563	7-24-92	1-1-93,	S.8452-A	Sen. Hannon Sen. Velella

Requires insurance companies to send notices of cancellation due to nonpayment of premiums to both the insured mortgagor and the mortgage investing institution or such other financial institution holding escrow funds for the payment of such premiums. Failure to send such notices to the mortgagee or the insured mortgagor would render the notice not effective.

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Section	Chapter	Signed	Effective	Bill	By
4229(i)(1)	625	7-24-92	6-30-92, generally but see chapter for details.	A.11638	Rules - Mr. Tallon

Authorizes the Superintendent of Insurance to suspend the otherwise applicable expense limits for debit life insurance even if the insurer cannot demonstrate that it will be in compliance in the next year and even if the suspension is for more than two years in succession. Previously the Superintendent did not have the discretion to grant a suspension for more than two years. Allows the Superintendent to require insurers to demonstrate that they are making good faith efforts to stay within the expense limitations. Further provides that the above two restrictions on the Superintendent's discretion are automatically reimposed on June 30, 1995.

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Section	Chapter	Signed	Effective	Bill	By
6403(b)(1)	190	6-23-92	6-23-92	S.3721	Sen. Velella

Empowers title insurance corporations to guarantee the correctness of searches for instruments affecting titles to cooperative units and proprietary leases.

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Section	Chapter	Signed	Effective	Bill	By
Laws of 1991 Chapter 320	484	7-17-92	7-17-92	A.11973-A	Rules - Mr. Grannis, et al.

Chapter 320 amended the Insurance Law to increase the maximum payment for lost earnings and expand the definition of basic economic loss under the no-fault automobile insurance law (contained in Article 51 of the Insurance Law). This legislation relates to the effective date of

Chapter 320 and certain adjustments of no-fault automobile insurance rates. Shall be deemed to have been in effect on and after November 12, 1991.

Amends the 1991 law as of its effective date, November 12, 1991. The 1991 law increased the maximum monthly no-fault insurance benefit for loss of earnings from work from $1,000 per month to $2,000 per month, and this chapter makes the increased benefit applicable to accidents arising out of the use and operation of motor vehicles on and after November 12, 1991. Does not apply to accidents occurring prior to that date. Any motor vehicle financial security insurance policy in force on and after November 12, 1991 that does not contain provisions complying with the new requirements effected by Chapter 320 of the Laws of 1991, as amended by this legislation, are to be construed as if such provisions were embodied therein.

Two additions are made to the Unconsolidated Laws. First, provides that the Superintendent of Insurance shall approve rate filings of insurers in accordance with Article 23 of the Insurance Law, reflecting an appropriate rate adjustment for basic economic loss coverage (including optional additional basic economic loss coverage) for policies to be issued or renewed in the future, reflecting unanticipated loss experience (either upwards or downwards) resulting from the increase in first-party benefits for loss of earnings from work effected by Chapter 320 of the Laws of 1991. Second, provides that any payment by an insurer of the increased benefit for loss of earnings from work made upon a policy issued or renewed prior to November 12, 1991, would be timely if made within 120 days of the date this act shall have become a law, meaning that no late payment interest would be due thereon in such circumstances.

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Section	Chapter	Signed	Effective	Bill	By
Laws of 1988 Chapter 630	284	6-30-92	6-30-92	A.9411-A	Mr. Lasher, et al.

Amends Section 5 of Chapter 630 of the Laws of 1988. Chapter 630 added a new Section 2130 to the Insurance Law authorizing the establishment of an excess line advisory organization (known as the Excess Line association of New York) and amended Section 2118, regarding excess line brokers. Chapter 630 was due to expire on July 1, 1989 and this chapter extends Chapter 630 an additional three years to July 1, 1995.

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2. Amendments to Laws Other Than the Insurance Law

This portion of the summary covers bills enacted at the 1992 session amending laws other than the Insurance Law that are of general interest to Departmental personnel and licensees. These brief descriptions of the law are intended only to provide highlights of the legislation. They should not be used in place of the full text of the law or regarded as interpretation of legislative intent or of Insurance Department policy.

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Section	Chapter	Signed	Effective	Bill	By
Banking Law 370-a New 492-a New 555-a New 583-a New 594 594-b New	142	6-16-92	8-15-92	S.1987-A	Sen. Farley

Amends the Banking Law to require that persons desirous of acquiring control of the business of certain specified licensees of the Banking Department, including insurance premium finance agencies, obtain prior approval of the Superintendent of Banks.

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Section	Chapter	Signed	Effective	Bill	By
Civil Practice Law & Rules 5003-a New	269	6-30-92	6-30-92, and shall be deemed to have been in full force and effect on and after 7/1/92 and shall apply to all actions settled on or after such date	S.8122-A	Sen. Mega

Amends the Civil Practice Law and Rules by adding a new Section 5003-a in relation to the prompt payment of funds after a settlement of litigation. Applies to all actions settled on or after July 1, 1992.

Subdivision (b) of Section 5003-a affects settlements by a defendant that is a municipality or any subdivision thereof or any public corporation that is not indemnified by the State. Payment must be made by such defendant within 90 days of tender by the plaintiff of a release and stipulation discontinuing the settling plaintiff's action.

Subdivision (c) applies the same rule to settlements when the settling defendant is the State, an officer or employee of the State entitled to indemnification pursuant to Section 17 of the Public Officers Law, or a public benefit corporation indemnified by the State.

Subdivisions (b) and (c) each provide that the 90-day requirement does not inure to the benefit of a defendant's insurance carrier. The subdivisions provide that such insurance carriers shall pay all sums due in accordance with the provisions of subdivision (a).

Subdivision (a) provides that a settling defendant, except those defendants described in subdivisions (b) and (c), shall pay within 21 days.

Provides in subdivision (f) that nothing in Section 5003-a will apply to settlements subject to Article 74 of the Insurance Law (Rehabilitation, Liquidation, Conservation and Dissolution of Insurers).

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Section	Chapter	Signed	Effective	Bill	By
Navigation Law	584	7-24-92	7-24-92	A.5327-F	Mr. DiNapoli, et al.
172(11)	585	7-24-92	7-24-92	A.12394	Rules
172(15-d) New					
174(2)					
174(9)					
176(2)(a)					
176(4)					
178-a New					
181(3)					
181(3)(e)(ii),(iii)					

Amends the Navigation Law to provide limited immunity for persons responding to oil spills and also requires financial responsibility on the part of facility owners and operators in regard to above-ground petroleum storage tanks. Underground storage tank owners and operators were already subject to federal financial responsibility requirements.

The Commissioner of Environmental Conservation is to promulgate appropriate regulations, in consultation with the Superintendent of Insurance, subject to stated maxima of $25 per barrel, $1 million per incident and $2 million per facility per year, constituting an annual aggregate. The bill sets forth criteria, including the availability and affordability of pollution liability insurance, relevant to determining the sufficiency of the amount of financial responsibility required, subject to such maxima. Limits the liability of an insurer providing coverage to satisfy the requisite financial responsibility to the type of risk assumed and the amount of coverage specified in the proof of financial responsibility.

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Section	Chapter	Signed	Effective	Bill	By
Retirement & Soc. Sec. Law 177(7)	118	6-1-92	6-1-92	A.8867-A	Rules - Mr. Lentol

Amends Section 177 of the Retirement and Social Security Law relating to eligible investments for the public retirement systems.

Chapter 603 of the laws of 1991 had broadened the scope of Section 177 to permit the retirement systems to invest in the separate accounts of domestic life insurance companies. That amendment, however, excluded the separate accounts of life insurance companies domiciled outside of New York State. The present Chapter corrects Section 177 to include the separate accounts of other life insurance companies, provided they are doing business in this State.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 201	331	7-17-92	7-17-92	S.6633-A	Sen. Sears

Amends Section 201 of the State Administrative Procedure Act (SAPA) to provide that each agency of state government shall strive to ensure that, to the maximum extent practical, its rules, regulations and related documents are written in a clear and coherent manner, using words with common and everyday meanings.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 202(2) 203(3)	620	7-24-92	10-1-92	A.11078	Mr.Sanders, et al.

Amends Section 202 of the State Administrative Procedure Act in regard to the expiration of a proposed rule making. Eliminates the distinction between rules for which the statute requires a public hearing and those rules for which a public hearing is not required. Changes the expiration date to 180 days after the latter of the publication of rule in the State Register or the date of the last public hearing announced in a notice of proposed rule making. Also amends the provisions regarding notices of continuation. Instead of two continuations of 90 days each, provides for one continuation of 185 days.

Additionally, eliminates the prohibition against an agency adopting the rule within 30 days after a notice of continuation appears in the Register. Provides that the notice of continuation cannot be submitted until 120 days after the latter of the date the notice appeared in the State Register or the date on which the last public hearing announced in the notice of proposed rule making was held on the rule.

Finally, provides that if within 90 days before the bill will expire, if a notice of revised rule making is submitted or the Office of Business Permits and Regulatory Assistance issues a notice pursuant to SAPA Section 202-c(5) or (7), the rule making will be extended an additional 90 days past the date on which it would have expired.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 202(4-a)(b) Re-lettered as (c) 202(a)(b) New 202(4-a)(c)(vii) 202(4-a)(c)(viii) 202(4-a)(c)(ix) Re-numbered as (x) 202(4-a)(c)(ix) New	335	7-17-92	10-1-92	S.6951	Sen. Sears

Amends Section 202(4-a)(b) of the State Administrative Procedure Act to provide that agencies shall publish and make available to the public an assessment of public comment for a revised rule. The assessment must be based upon any written comment submitted to the agency and any comments presented at any public hearing held on the proposed rule by the agency. The assessment must contain a summary and analysis of issues raised and significant alternatives suggested, a statement of reasons why such alternatives were not incorporated and a description of changes made as a result of the comments.

Adds a new subparagraph (ix) to Section 202(4-a)(c) to require the inclusion, with the notice of revised rule making, of an assessment of public comment, provided that if the assessment exceeds 2,000 words, the notice shall include only a summary in less than 2,000 words.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 202(5)(b)	524	7-24-92	7-24-92	S.5837-A	Sen. Sears

Amends Section 202(5)(b) of the State Administrative Procedure Act to provide that, upon adoption of a rule, comments submitted or presented to an agency by a legislative committee or commission or by a member or members of the Senate or Assembly shall be considered public comments and shall be summarized and analyzed in the assessment by the agency.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 202-a(3)	520	7-24-92	10-1-92	S.4986-B	Sen. Sears, et al.

Amends subdivision 3 of Section 202-a of the State Administrative Procedure Act (SAPA). Requires that the regulatory impact statement include the following information, where applicable; a citation to any scientific or statistical study, report or analysis that served as the basis for the rule, along with an indication of how the information was used to determine the benefits of the rule; a statement whether the rule exceeds any federal minimum standard, and if so, an explanation why the rule exceeds such standard; and a schedule of the estimated time periods for regulated persons to comply with the rule. Additionally, special districts are included among the local government units for which an agency must identify any proposed new mandates. The language regarding the identification of regulatory costs and duplication is also revised.

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Section	Chapter	Signed	Effective	Bill	By
State Admin. Procedure Act 202-c(7)(b)	447	7-17-92	10-1-92, but see chapter for details.	A.10019	Mr. Lopez, et al.

Amends Section 202-c(7)(b) of the State Administrative Procedure Act to require that notification by an agency to the Office of Business Permits and Regulatory Assistance required by this provision shall include a copy of the notice of public hearing published in the newspaper in circulation in the State and indicate the newspaper in which the notice was published and the date of publication. Also provides that notification to certain officers shall be in writing.

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Section	Chapter	Signed	Effective	Bill	By
Tax Law 1503(b)(1)(M) 1510(a) Laws of 1987 Chapter 817	640	7-24-92	10-1-92, but see chapter for details.	A.12166	Rules- Mr. Silver, et al.

Amends the Tax Law and Chapter 817 of the Laws of 1987, amending the Tax Law and the Environmental Conservation Law, constituting the Business Tax Reform and Rate Reduction Act of 1987, to make permanent certain provisions of such Chapter that expired with respect to taxable years beginning on or after January 1, 1992 that relate to franchise taxes on insurance corporations.

Permanently decouples certain federal tax provisions with regard to the computation of property and casualty insurance companies' New York entire net income. Also increases the additional franchise tax on premiums (other than life insurance premiums and accident and health premiums) from 1.2% to 1.3% for taxable years beginning on and after January 1, 1992. The overall effect is revenue neutral insofar as it results in a decrease in the net income base upon which the New York taxes are imposed while the tax rate for additional franchise tax upon property and casualty insurers is increased.

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Section	Chapter	Signed	Effective	Bill	By
Workers' Comp. Law 13(d) 13(h)(3)	364	7-17-92	7-17-92, but see chapter for exception.	S.7706-A	Sen. Lack

Amends Section 13(d)(2) of the Workers' Compensation Law to add a provision that undisputed claims for reimbursement will be handled by the parties themselves, and that with respect to disputed claims for reimbursement the sole remedy of the insurer or health benefit plan to recover on a claim shall be the submission of the controversy to mandatory arbitration or other alternative dispute resolution procedures is defined by rules and regulations promulgated by the Chair of the Workers' Compensation Board.

Also amends Section 13(h)(3) of the Workers' Compensation Law to establish time limitations on the submission of claims for computer searches. Further, provides that the amount paid to the prevailing party shall be increased by the amount of any fee paid to the arbitrator.

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Section	Chapter	Signed	Effective	Bill	By
Workers' Comp. Law 15(8)(d)	545	7-24-92	7-24-92, but	S.7709	Sen. Lack

Amends Section 15(8)(d) of the Workers' Compensation Law to permit an apportionment of liability for the Special Disability Fund within a single claim by disposition among the Special Disability Fund, carriers, self-insurers or employers. The apparent intent of the amendment is to reduce the substantial litigation that exists presently.

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Section	Chapter	Signed	Effective	Bill	By
Workers' Comp. Law 54(5)	164	6-16-92	6-16-92	S.7705	Sen. Lack

Amends subdivision 5 of Section 54 of the Workers' Compensation Law to provide that notice of cancellation of a workers' compensation insurance policy may be served upon any person or entity at an address designated by the employer.

Authorizes the employer to designate any person or entity at any address to receive the notice of cancellation, including the designation of one person or entity to receive notice on behalf of multiple entities insured under one policy. This measure is a proposal of the State Insurance Fund and is intended to save the costs and paperwork of multiple mailings.

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Section	Chapter	Signed	Effective	Bill	By
Workers' Comp. Law 201(5) 212(5) New	593	7-24-92	1-1-93, but see chapter for application.	A.7996-B	Rules - Mr. Lasher, et al.

Amends the Workers' Compensation Law in regard to disability benefits for spouses of employers and shall apply to contracts issued or renewed on or after January 1, 1993.

Amends Section 201(5) to delete an existing exclusion of the spouse of an employer from the definition of an employee for purposes of disability benefits coverage. Adds new subdivision 5 to Section 212 to provide that a spouse who is an employee of a covered employer shall be deemed to be included in the employer's disability benefits insurance contract or covered by a certificate of self-insurance or a plan under Section 211, unless the employer elects to exclude the spouse from the coverage. Provides a procedure for the filing of a notice of election by the employer, and provides that the election shall be final and binding upon the spouse named in the notice until revoked by the employer.

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B. REGULATIONS PROMULGATED

The following is a summary of Insurance Department Regulations promulgated in 1992. These brief descriptions of the Regulations are intended only to provide general information on the Regulations and, therefore, should under no circumstances be used in place of the full text of the Regulations or regarded as interpretation of Insurance Department intent or policy.

Regulation 35-D (11 NYCRR 60-2): Supplementary Uninsured Motorists Insurance (Promulgated 6/12/92; Effective 7/8/92)

This Regulation contains significant revisions to New York's Supplementary Uninsured Motorists (SUM) coverage. The changes are designed to update SUM coverage and improve its effectiveness. SUM is an optional coverage that drivers can purchase to protect themselves and other occupants of their vehicles if they are involved in an accident with an uninsured or underinsured vehicle.

First Amendment to Regulation 46 (11 NYCRR 9): Distribution and Sale of Publications of the Insurance Department (Promulgated 5/26/92; Effective 6/10/92)

The First Amendment to Regulation 46 establishes a new "Publications Price List" and "Prices for Additional Copies of Annual Statement Forms and Schedules."

Seventeenth Amendment to Regulation 62 (11 NYCRR 52): Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure (Promulgated 3/12/92; Effective 4/1/92)

This Amendment establishes revised minimum standards for Medicare supplement insurance in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA). Among other provisions, the standards are intended to provide for reasonable standardization of coverage, simplification of terms and benefits and facilitation of public understanding and comparison of such policies.

Twenty-Second Amendment to Regulation 68 (11 NYCRR 65): Regulations Implementing the Comprehensive Motor Vehicle Insurance Reparations Act (Promulgated 1/16/92 as an emergency measure; Effective 1/17/92; Promulgated 3/13/92 as an emergency measure; Effective 3/17/92; Promulgated 5/12/92 as an emergency measure; Effective 5/15/92; Promulgated 7/8/92 as an emergency measure; Effective 7/9/92; Promulgated 8/31/92 as an emergency measure; Effective 9/2/92; Promulgated 11/9/92; Effective 11/25/92)

The Twenty-Second Amendment to Regulation 68 implements significant changes to New York State's No-Fault Law as contained in Chapter 320 of the Laws of 1991.

Chapter 320 of the Laws of 1991 required, among other things, that no-fault insurers offer coverage for increased work loss benefits and offer a new basic economic loss coverage which is referred to in the regulation as Optional Basic Economic Loss or OBEL coverage.

This Amendment prescribes procedures to be followed by insurers in implementing the statutory requirements.

Amendment Twenty-Two A to Regulation 68 (11 NYCRR 65): Regulations Implementing the Comprehensive Motor Vehicle Insurance Reparations Act (Promulgated 2/13/92 as an emergency measure; Effective 2/14/92; Promulgated 4/9/92 as an emergency measure; Effective 4/14/92; Promulgated 6/5/92 as an emergency measure; Effective 6/12/92)

The New York Insurance Law only requires that no-fault coverage be afforded for accidents within the United States, its territories or possessions, and Canada. However, in promulgating the Twenty-Second Amendment, these geographical restrictions were inadvertently omitted from the mandatory no-fault endorsement.

Amendment 22-A reinserts the geographical restrictions into the endorsement.

First Amendment to Regulation 72 (11 NYCRR 174): Sale and Purchase of Exchange-Traded Call Options (Promulgated 5/1/92; Effective 6/1/92)

This Regulation establishes the rules for the sale and purchase of exchange-traded call options by insurers licensed by this Department. The First Amendment would make the Regulation inapplicable to property/casualty insurers. These insurers will now be regulated, with respect to covered call transactions, under Regulation 142.

Regulation 142, promulgated on April 22, 1992, governs permissible non-speculative *bona fide* hedging and income enhancement transactions. A non-speculative income enhancement transaction allows insurers to sell call options for securities they own.

Eighteenth Amendment to Regulation 83 (11 NYCRR 68): Regulation Implementing and Coordinating Article 51 of the Insurance Law and the Workers' Compensation Law with Respect to Charges for the Professional Health Services Specified in Paragraph (1) of Subdivision (a) of Section 5102 of the Insurance Law (Promulgated 2/14/92; Effective 3/4/92)

The Eighteenth Amendment to Regulation 83 was readopted on an emergency basis in January, having previously been promulgated on an emergency basis in August and November of 1991. The Amendment provides for increases in the provider fee schedules, in recognition of inflation and increased operating costs. It adopts the Revised Fee Schedule of the Workers' Compensation Board where applicable, and provides for commensurate increases for care and services not covered by that schedule.

Nineteenth Amendment to Regulation 83 (11 NYCRR 68): Regulation Implementing and Coordinating Article 51 of the Insurance Law and the Workers' Compensation Law with Respect to Charges for the Professional Health Services Specified in Paragraph (1) of Subdivision (a) of Section 5102 of the Insurance Law (Promulgated 8/19/92 as an emergency measure; Effective 9/1/92; Promulgated 10/26/92; Effective 11/18/92)

The Nineteenth Amendment to Regulation 83 revises the fee schedules established by the Superintendent of Insurance where there are no similar workers' compensation schedules. Charges for the services listed in the fee schedules, as amended, may not exceed the charges permissible under such schedules and apply to charges for services performed on or after September 1, 1992.

Second Amendment to Regulation 100 (11 NYCRR 169): Noncommercial Private Passenger Automobile Insurance Merit Rating Plans (Promulgated 3/3/92; Effective 3/25/92)

The Second Amendment to Regulation 100 requires automobile insurance companies to provide consumers with a written explanation for any surcharges imposed on their policies. In addition, a vehicle must sustain more than $1,000 in property damage before its driver can be subject to a surcharge.

The initial emergency action was necessitated to allow insurers sufficient time to develop procedures to implement the statutorily mandated changes, the last of which took effect November 27, 1991.

The revised Amendment extends, to July 1, 1992, the time that insurers are, however, free to implement the required changes at an earlier date. The original Amendment has also been revised to conform other recent changes in applicable law, including an increase of the monetary threshold for accidents that must be reported to the Department of Motor Vehicles (from $600 to $1,000) and to prohibit insurers from assessing surcharges in certain circumstances involving the use of non-owned livery vehicles.

Sixteenth Amendment to Regulation 101 (11 NYCRR 70): Medical Malpractice Insurance: Required Notices and Rate Modifications (Promulgated 1/16/92 as an emergency measure; Effective 1/17/92; Promulgated 2/21/92; Effective 3/11/92)

The Sixteenth Amendment to Regulation 101 establishes the conditions under which medical malpractice insurance policies can now be made available to physicians on both a claims-made and an occurrence basis.

Seventeenth Amendment 'to Regulation 101 (11 NYCRR 70): Medical Malpractice Insurance: Required Notices and Rate Modifications (Promulgated 7/8/92; Effective 7/9/92)

Legislation passed in 1991 extended the authority of the Superintendent to establish stabilized rates for medical malpractice insurance for the policy periods ending June 30, 1993, and to impose surcharges to overcome any deficiencies that resulted during the period in which rates were stabilized. In addition, Chapter 277 of the Laws of 1992 extended the excess medical malpractice program purchased by hospitals for their attending physicians.

The Seventeenth Amendment establishes rates, and surcharges where required, for the policy period July 1, 1992 through June 30, 1993.

First Amendment to Regulation 124 (11 NYCRR 152): Physicians and Surgeons Insurance Merit Rating Plan: Risk Management Credits (Promulgated 3/27/92; Effective 4/15/92)

The First Amendment to Regulation 124 establishes the terms and conditions under which insurers may provide a premium credit of up to 5% for insured physicians who successfully complete a qualified risk management course. All courses must be approved by the Superintendent and must meet minimum standards as set forth in the Amendment in order to qualify for the credit.

Second Amendment to Regulation 126 (11 NYCRR 95): Valuation of Annuity and Single Premium Life Reserves (Promulgated 11/25/92; Effective 12/16/92)

Regulation 126 specifies a number of requirements and guidelines including those for the cash flow projection of assets and liabilities under various interest scenarios.

This Amendment redefines the opening asset balance to be used in performing cash flow testing to include assets used to support asset default; redefines the annual default expense charges in terms of the AVR (asset valuation reserve) instead of the MSVR (mandatory securities valuation reserve); and redefines the minimum interest rate to be used in performing cash flow testing.

Regulation 142 (11 NYCRR 177): Rules Governing Bona Fide Hedging and Income Enhancement Transactions of Authorized Property/Casualty Insurers (Promulgated 4/22/92; Effective 6/1/92)

Chapter 496 of the Laws of 1989 as amended by Chapter 32 of the Laws of 1990 amended Section 1403 of the Insurance Law to permit domestic property/casualty insurers to effect or maintain non-speculative hedging transactions and other transactions for non-speculative income enhancement purposes.

Regulation 142 prescribes the times of transactions authorized for such insurers, the limitations that apply to such transactions, and the procedures such insurers must follow in order to effect and maintain those transactions.

Regulation 143 (11 NYCRR 41): Accelerated Payment of the Death Benefit Under a Life Insurance Policy (Promulgated 4/27/92; Effective 5/13/92)

Regulation 143 establishes the rules for accelerated payment of death benefits upon diagnosis of terminal illness defined as a life expectancy of 12 months or less, or of a medical condition requiring extraordinary medical care or treatment regardless of life expectancy. The Regulation also provides advertising and disclosure requirements, benefit levels, benefit eligibility, non-forfeiture and reserve standards.

Regulation 144 (11 NYCRR 39): Minimum Standards for the Long Term Care Security Demonstration Program established under Chapter 454 of the Laws of 1989 (Promulgated 11/10/92; Effective 11/25/92)

This Regulation establishes the minimum standards for long-term care insurance in this State in order to qualify for Medicaid reinsurance under the Long Term Care Security Demonstration Program authorized by Section 367-f of the Social Services Law and Section 3229 of the Insurance Law.

C. CIRCULAR LETTERS ISSUED*

NO.	DATE	ADDRESSED TO	SUBJECT
1	2/5/92	All Authorized Life Insurance Companies, Accredited Life Reinsurers, Fraternal Benefit Societies And Charitable Annuity Societies	Securitization of Assets
2	3/17/92	All Licensed Life Insurers	Claims Paying Ability and Credit Rating Downgrade Bail-Out Provisions in Annuity Contracts and Funding Agreements
3	7/9/92	All Life Insurers Licensed to Transact Life or Accident and Health or Annuities in New York	Publication of an Information Brochure on the Life Insurance Company Guaranty Corporation of New York
4	5/12/92	All Motor Vehicle Self-Insurers and Insurers Licensed to Write Motor Vehicle Insurance in New York	1) Unpaid No-Fault Conciliations And Arbitration Awards and 2) Change in Central Reporting Organization for Total Losses
5	5/5/92	All Insurance Companies Authorized to Transact Motor Vehicle Liability Insurance Business in New York State	Motor Vehicle Law Enforcement
9	6/5/92	All Insurers Licensed to Write Motor Vehicle Physical Damage Insurance in New York State and Producer & Adjuster Window Glass	Scope of Referrals to Motor Vehicle Repair Shops Performing Window Glass Replacement for Repairs
10	6/16/92	All Insurers, Except Article 43 Corporations, Licensed to Write Accident and Health Insurance in New York	Payment for Hospital Services Required by Chapter 55 of the Laws of 1992
11	12/11/92	All Authorized Motor Vehicle Insurers and Insurance Producer Organizations	Policy Declarations Page(s) Requirements

12	8/11/92	All Authorized Life Insurance Companies, Accredited Life Insurers, Fraternal Benefit Societies and Charitable Annuity Societies	Maximum Reserve Valuation And Maximum Life Policy Nonforfeiture Interest Rates Under Sections 4217, 4218, and 422(k) of the New York Insurance Laws, as Amended in 1982, 1983, 1985, 1986, 1987, 1988. and 1990
14	9/8/92	All Insurers Licensed to Write Accident and Health Insurance in New York State	Chapter 501 of the Laws of 1992 —Effective Date Provisions for Community Rating and Open Enrollment
15	9/18/91	All New York Licensed and Accredited Property and Casualty Insurers and Reinsurers	Exposure to Hurricane Andrew and Iniki Losses
16	9/24/92	All Licensed Insurers in New York State	Appropriate Dating of Documents Sent to Policyholders
17	10/8/92	All Insurers Licensed to Write Motor Vehicle Liability Insurance in New York State and Insurance Producer Organizations	Status of Litigation Involving Regulation No. 35-D Supplementary Uninsured Motorists (SUM) Insurance
18	12/14/92	All Authorized Title Insurers in New York State	Closing Protection Letters to Lenders from Title Insurers
19	10/30/92	All Authorized Property/Casualty Insurers, Insurance Producer Organizations, and Advisory Rate Service Organizations	Prospective Loss Costs and New Reporting Forms
Supp. # 1 to CL#19	11/18/92	All Authorized Property/Casualty Insurers, Insurance Producer Organizations, and Advisory Rate Service Organizations	Prospective Loss Costs and New Reporting Forms
20	11/23/92	Authorized Insurers, Fraternal Benefit Societies, Pension Funds and Retirement Systems, Charitable Annuity Societies, Accredited Reinsurers and Licensed Excess Line Brokers	Notification of New Debt Collection Legislation/ Penalties for Delinquent Payments

*The following Circular Letters were not issued in 1992:
#6
#7
#8
#13

D. IMPORTANT DEVELOPMENTS OF 1992 IN MAJOR LITIGATION INVOLVING THE INSURANCE DEPARTMENT

Empire Blue Cross and Blue Shield (Empire) v. Curiale, as Superintendent of Insurance of the State of New York, Appellate Division, Third Department.

Petitioner Empire, a not-for-profit corporation licensed to provide insurance coverage under Article 43 of the Insurance Law, brought this Article 78 proceeding in July 1992, in Supreme Court, Albany County, seeking relief from several decisions made by the Superintendent.

Specifically, Empire asked the court to direct the Superintendent to do the following:

1. Reconsider and approve Empire's January 1992 rate request, which had been modified by a 4/1/92 Opinion and Decision of the Superintendent.

2. Withdraw his rescission of a rate increase, to take effect in October 1992, which had been provisionally granted by the April Opinion and Decision and rescinded after enactment of community rating legislation in July 1992.

3. Reconsider and approve Empire's Three Year Plan to Restore Reserves.

4. Approve, over a period of three years, rate increases for Empire that will allow restoration of the insurer's reserves to the minimum level required by Section 4310 of the Insurance Law.

In a decision dated October 2, 1992, Supreme Court Justice Harold J. Hughes annulled the determination of the Superintendent that had rescinded his approval of petitioner's October 1992 rate increase. Justice Hughes further ordered the Superintendent to require that petitioner submit a plan to him that will within a three-year period bring its statutory reserve fund up to the level required by Section 4310 of the Insurance Law.

The Department filed a notice of appeal in the Appellate Division, Third Department, and requested a stay of Justice Hughes October 2 decision. Said stay was granted and on October 27 it was continued, provided the Department perfected its appeal by November 27, 1992, which it did.

Subsequently petitioner, pursuant to a separate application, was granted a rate increase effective January 1993. Chapter 1 of the Laws of 1993 was signed into law and provided that Empire submit a six year plan to restore its statutory reserves. Based upon the forgoing the parties agreed that the relief requested in this action had become moot and the case was settled by stipulation dated February 12, 1993.

American Transit Insurance Company v. Curiale, as Superintendent of Insurance

Matter of American Transit Insurance Company

Actions consolidated in Supreme Court, New York County.

These actions concern the petition of the Superintendent of Insurance for an order to take possession of the property of and liquidate the business of American Transit Insurance Company (ATIC), a licensed property and casualty insurer.

A Report on Examination dated June 25, 1991, conducted pursuant to the statutory authority of the Superintendent, showed ATIC to be insolvent as of December 31, 1989 in the amount of approximately $40 million. Despite a subsequent surplus contribution by the insurer's parent company, the Insurance Department believes that ATIC remains insolvent. After correspondence and further discussions between the parties, respondent failed to make good its impairment of capital and the Department determined that ATIC's further transaction of business would be hazardous to its policyholders, creditors and the public.

Accordingly, the Superintendent initiated the second-cited matter. In addition to seeking authority to liquidate the insurer, the action asks for a restraining order halting ATIC from continuing to transact business or in any other way disposing of assets. The first matter, initiated by ATIC, sought to enjoin the Superintendent from commencing his action.

A November 13, 1991 order of Justice Saxe had required that the Department apply to the court by Order to Show Cause prior to taking any regulatory action against the insurer. In April 1992 the Appellate Division, First Department, affirmed that portion of Justice Saxe's order. The Appellate Division, First Department, also appointed Dean Frank J. Macchiarola of Cardozo Law School as a referee to conduct a hearing and render a report to the Court on all factual issues concerning the liquidation proceeding as well as the related action for injunctive relief.

As 1993 began, the hearing before the court-appointed referee continued. ATIC has pending before the Supreme Court, New York County, a motion to dismiss the Department's action.

New York State Conference of Blue Cross and Blue Shield Plans, et al. v. State of New York, et al.,

New York State Health Maintenance Organization Conference, et al. v. State of New York, et al.,

Cases consolidated in Supreme Court, Albany County.

Plaintiffs in the first matter are an unincorporated association and its members that are all of the Blue Cross and Blue Shield Plans licensed to write medical and hospital expense indemnity insurance in the State of New York under Article 43 of the Insurance Law. Plaintiffs in the second matter are an unincorporated association of 27 health maintenance organizations providing care and services to approximately 2.5 million people in 57 counties of New York State. Both these proceedings sought an order that certain provisions of New York Law, relating to the excess medical malpractice insurance program, were unconstitutional and therefore null and void and without force and effect.

Both plaintiffs sought a permanent injunction prohibiting defendants, which include the Governor and Superintendent of Insurance, from enforcement of such laws, ordering that defendants make an accounting of monies received and paid pursuant to the challenged provisions and declaring that plaintiffs are entitled to a share of the above funds. (Also note related case of HANYS Insurance Company, Inc. and HANYS Member Hospitals Self-Insurance Trust v. Curiale, et al., Supreme Court, New York County, wherein petitioners, the first an insurer licensed to write excess medical malpractice insurance in New York and the second a self-insurance trust arrangement authorized to issue and administer excess medical malpractice insurance coverage for its participating hospitals, sought to protect any infringement of their rights that might result from the decision in the above-cited matter.)

Chapter 1 of the Laws of 1993 contains an appropriation of $150 million from the State of New York General Fund to be paid to plaintiffs in full satisfaction of all claims in this action. The settlement requires that all such funds received by plaintiffs shall be used to mitigate the impact of current or future rate increases on contracts by said plaintiffs that are subject to the most severe rate increases, including experience-rated, contracts.

Accordingly, the plaintiffs agreed to the dismissal of this action with prejudice. Note that the HANYS case remains pending.

Travelers Insurance Company v. Cuomo, McBarnette and Curiale,

Health Insurance Association of America, et al. v. Chassin, Bane, Curiale and Abrams,

Cases consolidated in United States District Court, Southern District of New York.

Plaintiffs include many insurers licensed to write group accident and health insurance in New York. Defendants include the Governor of New York, the Executive Deputy Commissioner of Health and the Superintendent of Insurance. This action challenges three surcharges placed on hospital bills, one pursuant to Section 2807-c(1)(b) of the Public Health Law and the other two authorized by Chapter 55 of the Laws of 1992.

The first surcharge results in an increase in the hospital rates charged for all patients other than those covered by Blue Cross and Blue Shield, a health maintenance organization (HMO) or a government plan such as Medicare. The first surcharge is paid directly to the hospital.

The second surcharge further increases the hospital rate for patients insured by commercial insurers. Although initially paid to the hospital, the monies collected eventually are deposited into the State's General Fund.

The third surcharge results in an increase in the hospital rates charged for patients insured by HMOs. The monies collected are ultimately deposited into the State's General Fund.

Travelers argued that, with respect to those policies issued to benefit plans covered by the Employee Retirement Income Security Act (ERISA), the state is pre-empted from application of any of the surcharges. Travelers made the same claim with respect to those self-insured health benefit plans that it administers or to which it issues stop loss policies. Plaintiffs in the second-cited proceeding made similar claims.

On February 3, 1993, in response to a plaintiffs' motion for summary judgment, Judge Louis J. Freeh issued an order finding all three challenged surcharges to be pre-empted by ERISA, and enjoined the State from enforcing any of those surcharges against either commercial insurers or HMOs with respect to coverage issued to ERISA plans. The court further enjoined the State from enforcing the surcharges against any commercial insurer providing stop-loss coverage to self-funded ERISA plans.

The court also ruled that the imposition of the first two surcharges was pre-empted by the Federal Employee Health Benefit Act (FEHBA), a program through which eligible federal employees may select coverage from any one of the participating insurance carriers in their region. Accordingly, the State was enjoined from enforcing those surcharges against any of the insurers participating in the FEHBA program.

The State has filed a notice of appeal to the United States Court of Appeals for the 2nd Circuit. Judge Freeh ordered a stay of his ruling with respect to the first surcharge and, with respect to the other two surcharges, ordered that affected parties continue to make payment into an escrow account pending final resolution of this matter.

Hospital Association of New York State (HANYS) v. Chassin, as Commissioner of Health and Curiale, as Superintendent of Insurance of the State of New York, Appellate Division, Third Department.

Petitioner HANYS, a not-for-profit corporation providing services to its members, which are not-for-profit and voluntary public health care providers from throughout New York State, brought this Article 78 proceeding in Supreme Court, Albany County, to challenge the method of implementation of a surcharge placed on hospital bills pursuant to Sections 348 and 349 of Chapter 55 of the Laws of 1992 (See related proceedings of Travelers Insurance Company v. Cuomo, McBarnette and Curiale and Health Insurance Association of America, et al. v. Chassin, Bane, Curiale and Abrams, Above.)

HANYS' complaint focused on the 11% Commercial Insurance Carrier Adjustment mandated by the above-cited sections. Based upon interpretive letters issued by the Department of Health, its member hospitals were required to estimate the amount of payments they would be entitled to receive from commercial insurers and pay such estimated amounts, in advance of receipt, into the Supplementary Payment Rate Conversion Factor Statewide Pool.

HANYS sought a declaration that said State actions were in violation of law and requested a permanent injunction prohibiting implementation and enforcement of the requirement for payment by hospitals of the 11% adjustment.

In an Order and Judgment dated November 18, 1992 Supreme Court Justice Harold J. Hughes sustained the challenged statutes and dismissed the complaint in its entirety. Petitioner filed a Notice of Appeal and request for a stay pending appeal. In December, the Appellate Division, Third Department, denied the request for a stay.

E. REGULATORY LICENSE HEARINGS AND STIPULATIONS EXECUTED IN 1992

After hearings in the Insurance Department, 60 licensees suffered revocations, 5 had their license applications denied, 2 had their license applications granted and 1 had its name change request granted. In addition, 20 licensees were fined a total of approximately $138,000.

Sixteen licensees agreed to surrender their licenses and 316 agreed to pay fines totaling approximately $1,800,000.

III. 1993 LEGISLATIVE RECOMMENDATIONS

A. GOVERNOR'S PROGRAM BILLS

1. Article 43 Corporations: Program Bill No. 1

To assure that persons selected as members of the board of directors of health service, hospital service, or medical expense indemnity corporations, of a specified annual premium volume are representative of the positions for which they have been nominated, including a residency requirement for public directors; and to require that certain key committees of the board of directors of such corporations consist solely of directors who are not officers or employees.
Introduced and passed as a part of a broader measure (Senate Bill 430 (Rules), Assembly Bill 655 (Rules)) which became Chapter 1 of the Laws of 1993.

2. Establishment of Standard Insurance Policies for Individual and Small Group Health Insurance: Program Bill No. 2

To require the Superintendent of Insurance to adopt regulations mandating the standardization of individual and small group health insurance policies; to prohibit the sale of any individual or small group health insurance policy after a date no later than January 1, 1995, unless the benefit structure of any such policy conforms to a standardized plan of coverage designated by the Superintendent; and to provide for a technical advisory group regarding the components of the benefit plan.

One of the goals of the community rating and open enrollment requirements of Chapter 501 of the Laws of 1992 is to promote competition among insurers on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction and low administrative costs, rather than on the basis of differing underwriting practices and varying premium rate methodologies. However, this goal may not be accomplished if insurers are permitted to develop and offer a multiplicity of benefit packages, each with its own pool of insureds, and each with its own community rate. A variety of plans may be developed with minimal or reduced benefits for the sole purpose of reducing price. Healthier risks may be attracted to such lower priced/lower benefits packages, realizing that the open enrollment and portability requirements of Chapter 501 will permit them to move to a higher priced/higher benefits plan, with credit for pre-existing condition waiting periods, should their health status deteriorate. The more comprehensive plans may therefore consist predominantly of high risk individuals.

By requiring standardized benefit plans, individuals and small groups would be able to easily compare offerings from competing insurers. Insurers would also not be able to attract better risks from comprehensive benefits plans by offering limited benefits plans at reduced rates. Medicare supplement insurance is already subject to standardization requirements by operation of federal law.
Senate Bill 4716 (Sens. Velella, Tully), Assembly Bill 5914 (Mr. Grannis, Mr. Gottfried, *et al.*

3. Managed Care: Workers' Compensation: Program Bill No. 101

To reduce the costs and enhance the quality of medical and other health care services available to workers' compensation insurance policyholders, insurers and self-insurers by providing a managed care alternative for delivery of such services.
Senate Bill 5886 (Sen. Lack), Assembly Bill 7196 (Ms. Christensen)

4. Impaired Newborn Infants Compensation System: Program Bill No. 133

To create a system to compensate newborns who suffer a medical impairment at birth, without need to prove physician fault, and to provide increased and more effective review of physicians and others who provide medical care in connection with newborns.
Assembly Bill 8097 (Rules)

B. INSURANCE DEPARTMENT BILLS FOR 1993

1. Life Insurers - Superintendent's Authority When Surplus is Inadequate

a) To identify inadequately capitalized life and accident health insurance companies.

b) To provide the Superintendent of Insurance with increasing authority over a life or accident and health insurance company as its financial condition deteriorates.

c) To protect the confidentiality of the information obtained by the Superintendent.

The life insurance industry has been plagued in recent years by insolvencies of some major companies. The media attention to the problems in the insurance industry has brought about serious concerns on the part of the consumers regarding insurance company solvency. Consumers need the security of knowing that their insurance protection will be available when they need it.

New Section 1322 establishes a risk-based capital formula that has been designed to identify inadequately capitalized life and accident and health insurers. This formula will provide the Superintendent with increased authority over life and accident and health insurance companies as their financial condition deteriorates.

The formula is designed to be a threshold capital formula rather than a target capital formula. It is designed to identify companies with capital levels that require regulatory attention, not to differentiate among adequately capitalized companies. It would be entirely inappropriate to use this formula to rate or rank adequately capitalized companies.

The new Section 1322 will provide the Superintendent with a powerful and highly effective new tool in assuring a marketplace of secure and well-capitalized companies for the life and accident and health insurance consumer. Working with the formula sensitizes both the companies and the Superintendent, as well as other regulators, to the risk inherent in various modes of operation; this fact in itself will have a beneficial impact on New York's industry, as well as the industry throughout the United States.

The formula and a model act supporting the implementation of the formula, were adopted by the National Association of Insurance Commissioners (NAIC) in December 1992. Its adoption was recommended by the Industry Advisory Group that was involved in the development of the formula and model act and was supported by the American Council of Life Insurers.

The risk-based capital formula will greatly enhance New York's strong, effective regulation of insurers.
Senate Bill 4049 (Sen. Velella), Assembly Bill 6282 (Mr. Grannis, Mr. Bianchi, *et al.*)

2. Enhancement of Solvency of Life Insurers - Actuarial Opinion and Memorandum

To revise Section 4217 of the Insurance Law to conform the requirements for an actuarial opinion of reserves from every life insurance company doing business in this state to the Model Standard Valuation Law amendments adopted by the National Association of Insurance Commissioners in 1990 and amended in 1991.

The amendments to the Model Standard Valuation Law were developed essentially to strengthen solvency of life insurers by requiring, under certain circumstances, an actuarial opinion and memorandum from a qualified actuary regarding the adequacy of reserves. New York was the pioneer in this area and already has legislation on the books requiring an actuarial opinion and memorandum, but only for annuities, guaranteed interest contracts, and certain single premium life insurance policies. However, prior to the introduction of this model legislation, states other than New York did not require an actuarial opinion and memorandum as to the adequacy of assets supporting policy and contract obligations, and, as noted above, New York's law required an opinion and memorandum only on particular liabilities. As of October 1992, 14 states have adopted their version of this Model Law, and legislation is pending in many other states.
Senate Bill 2593 (Sen. Velella), Assembly Bill 6287 (Mr. Grannis, Mr. Bianchi)

3. Elimination of Sunset on Certain Provisions Regarding Demutualization of Life Insurers

To make permanent certain provisions in Section 7312(t) of the Insurance Law, as added by Chapter 24 of the Laws of 1992, relating to the procedure to be followed in the reorganization of domestic mutual life insurers.

Section 7312 of the Insurance Law contains detailed provisions governing the process by which a domestic mutual life insurer may be reorganized into a stock life insurer. The 1992 amendment to Section 7312(t) was made to ensure that once a mutual life insurer had decided to reorganize and its plan of reorganization had been approved by the Superintendent of Insurance after a public hearing, the conversion would be accomplished quickly.

Experience has shown that the amendment was a crucial element in enabling the demutualization process to conclude in an orderly fashion. Accordingly, the Department recommends that the provisions be made permanent.
Senate Bill 2595 (Sen. Velella), Assembly Bill 6288 (Mr. Grannis, Mr. Bianchi)

4. Credit Card/Checking Account Group Property/Casualty Insurance

To permit group property/casualty insurance for credit card, debit card or checking account holders covering certain personal property purchased, rented or leased with the credit card, debit card or checking account and for extended warranties covering the property so purchased, and certain other coverages.

With appropriate safeguards, group coverages for authorized users of credit cards, debit cards or checking accounts, personal property purchased with the cards or checks, extended warranties covering the property, baggage in transit, and loss of, damage to, or loss of use of, rental vehicles or property used in connection with the motor vehicles rented with the cards or checks, represent desirable protection from the consumer's point of view. Because of the size and nature of the groups involved, the costs are relatively low, usually with automatic coverage from the moment of purchase or rental with the card or check. These coverages are typically offered as part of nationwide programs in which New York cardholders should be permitted to participate.

The coverages set forth in this bill, except for the extended warranty coverage for property other than motor vehicles and aircraft, are authorized kinds of insurance pursuant to Section 1113(a) of the Insurance Law. The extended warranty coverage written pursuant to the bill would be deemed to be miscellaneous property insurance so that it could be written as that kind of insurance pursuant to Section 1113(a)(5) of the Insurance Law.

The bill specifies the types of coverages that may be provided and establishes certain limitations and parameters. The Superintendent is authorized to determine that other coverages may be substantially similar to one of the coverages enumerated. This coverage is not intended to provide traditional forms of coverages such as homeowners coverage, but to complement existing forms of coverage. Motor vehicle insurance is limited, except as specifically provided in connection with rental or leased vehicles.

This bill should be enacted at this time in order to provide necessary consumer protections and to authorize the provision of group coverage in certain specified circumstances for authorized users of credit cards, debit cards or checking accounts. Since a market for these credit card, debit card or checking account coverages is expected to evolve further, however, it is desirable that a December 31, 1997 sunset be enacted for the part of the bill dealing with this group coverage so that the Legislature will have the opportunity to review the efficacy of the law in light of developments in the marketplace as well as the possibility of additional changes in the law dealing with warranties in general.
Senate Bill 2599 (Sen. Velella), Assembly Bill 6289 (Mr. Grannis, Mr. Bianchi)

5. Regulation of Warranty Business

To redefine when the issuance of a warranty constitutes the doing of an insurance business in this State; to permit authorized insurers to provide insurance to a warrantor to indemnify such warrantor for warranty obligations; to permit authorized insurers to issue a warranty as insurance; and to license and regulate warranty administrators.

This bill would amend the Insurance Law to create a comprehensive structure for the regulation of the business of warranties in New York State by 1) defining warranty for the first time in the Insurance Law; 2) clearly defining the circumstances under which the issuance of a contract of warranty constitutes the doing of an insurance business; 3) establishing a new kind of insurance to (a) indemnify warrantors for warranty obligations, and (b) permit insurers to issue warranties; and 4) requiring that warranty administrators be licensed.

Since 1959, the Insurance Law has provided that the issuance of warranties constitutes the doing of an insurance business if done as a vocation and not merely incidental to one's legitimate business or activity. This has resulted in uncertainty as to how and when the Insurance Law applies to warranties, making it extremely difficult to enforce the law uniformly. Firstly, the term "warranty" is not defined. Secondly, the use of the term "incidental" is vague and indefinite and subject to varying interpretations. This requires a case-by-case evaluation, resulting in a significant expenditure of administrative time and expense in reviewing numerous programs. In fact, since this bill was first introduced in 1991, the Department has been involved in over two dozen warranty investigations and has opined on many more. Several of these matters have been settled, others are pending further investigations and some have been referred to the Attorney General.

This bill, for the first time, defines what a warranty is, and establishes clear rules as to when, and by whom, warranties may be issued without constituting the doing of an insurance business.

The bill defines warranty to broadly include the assumption of the risk of, or all or a part of the cost of, repair or replacement of property, or other remedial action where the assumption is conditioned upon a defect in material or workmanship, deterioration, depreciation, wear and tear, breakdown, failure, or deficiency in operation of the property. It does not include the assumption of any risk conditioned upon any external cause, including lack of due care or misuse. For example, theft or natural catastrophe, or intentional failure to maintain the property could not be covered under a warranty.

Under new subparagraph (E) of Section 1101(b)(1), making, or proposing to make, any contract of warranty (other than as provided in paragraphs (2), (3), and (4)), constitutes the doing of an insurance business.

New paragraph (3) of 1101(b) focuses on when making, or proposing to make, warranties does not constitute the doing of an insurance business. Warranties made by specified persons under specified conditions may permissibly cover the amount needed to refund the cost of the covered part, or the purchase price of the property. However, warranties may not permissibly cover payment of consequential or incidental damages in excess of $250.

For example, the following would be considered insurance: 1) an automobile parts warranty that covers unlimited consequential damage to non-covered parts of an automobile if the covered part is defective; 2) an automobile warranty that would cover unlimited consequential damages to an automobile other than the automobile warranted should the warranted automobile damage the other automobile as a result of the malfunction of a covered part; and 3) unlimited incidental damages, such as towing costs, or living or car rental expenses.

Certain specified persons having a connection to the property warranted may make, or propose to make, a contract of warranty without constituting the doing of an insurance business in the State (subject to the $250 limitation for consequential or incidental damages). These persons include the following:

- a manufacturer, distributor, lessor or seller of the property warranted, a wholly-owned subsidiary thereof, or a parent that owns 100% thereof, if the warranty is made within 60 days of the sale or lease of the property or prior to the expiration of a warranty made by the same warrantor;

- a repairer, a wholly-owned subsidiary thereof or a parent that owns 100% thereof, with regard to repairs performed by the repairer, if the warranty is made within 60 days of the repair; and

- a person whose vocation includes repairing the type of property warranted, a wholly-owned subsidiary thereof, or a parent that owns 100% thereof, who inspects the warranted property and: 1) the warranty does not exceed the scope of the inspection; 2) the warrantor does not derive more than 25% of its gross income from the sale of warranties; 3) the warranty is made within 60 days of the inspection; and 4) the warranty does not cover a motor vehicle or aircraft.

New paragraph 4 provides that, notwithstanding paragraph 1 of the subsection, making, or proposing to make, a contract by a pest controller to provide treatment to control or eliminate pests from property shall not constitute the doing of an insurance business under certain specified circumstances.

Other than for motor vehicles and aircraft, the Insurance Law does not currently authorize insurance providing coverage similar to that provided under a warranty or insurance for indemnification of warrantors for warranty obligations. There is clearly a market for this kind of insurance in regard to other kinds of property, as reflected by the number of policy filings that this Department has had to refuse to approve. The proposed legislation would create a new kind of insurance, entitled "warranty insurance and warrantor insurance," to authorize this insurance coverage in regard to all types of property, including motor vehicles and aircraft.

Warranty insurance would permit insurers to issue warranties as insurance policies directly to the consumer, providing a regulated insurance alternative to warranties sold by those in the chain of manufacture or distribution. Existing Insurance Law cancellation and nonrenewal provisions are not appropriate for warranty insurance, and this bill would establish provisions specifically tailored to the unique characteristics of warranty insurance.

Warrantor insurance would permit a warrantor that is not doing an insurance business to obtain insurance indemnifying it for its warranty obligations. Warrantors often represent to purchasers, *i.e.*, warrantees, that their warranties are backed up by insurance. Currently, the purchaser has no way of confirming whether there is in fact such insurance. Even where there is, the purchaser has no certainty that the insurance will still be in effect when called upon. Additionally, the purchaser has limited or no recourse directly against the insurer upon the default of the warrantor.

This bill mandates certain policy provisions and minimum cancellation requirements for the protection of both warrantors and warrantees. Insurance companies writing warrantor insurance would generally be responsible for the mailing or delivery of evidence of insurance coverage to each warrantee. The warrantees would be additional insureds under the policy and would be entitled to make claims directly to the insurer should the warrantor refuse to or be unable to perform under the warranty. Moreover, if the warrantor insurance policy is cancelled or terminated, the warrantee's coverage would continue until the underlying warranty expires or is terminated.

Warranty insurance and warrantor insurance would be subject to file-and-use rate filing requirements. There would be no coverage under the Property/Casualty Insurance Security Fund. This kind of insurance could not be written on an excess line basis nor be adjusted by a public adjuster.

This bill would provide for the licensing and regulation of warranty administrators. While under existing law warranty administrators are not licensed, their functions often include acting as insurance agents, brokers, consultants or adjusters. However, because of the interdependence of the insurance and warranty aspects of warranty programs, the existing licensing structure is inadequate.

A warranty administrator often develops warranty programs that it markets to sellers or other persons who will issue the warranties to the consumer. The warranty administrator usually requires and holds contributions from a warrantor to be used to satisfy warranty claims against the warrantor. As part of the program, the warranty administrator often requires that the participating warrantor obtain insurance from specified insurers to reimburse the warrantor for losses under the warranty. When a warranty claim arises, the warranty administrator determines whether repair work or other action is merited and, if so, authorizes performance under the warranty. Where there is insurance, the administrator simultaneously adjusts the warrantor insurance claim because the authorization to perform the work under the warranty thereby triggers the obligation of the insurer to reimburse the warrantor.

The warranty administrator is at the heart of most warranty programs. It is difficult to isolate the insurance functions from the non-insurance functions and it is not always clear when the administrator's activities are within the current scope of Insurance Department regulation. Because of the dual nature of the administrator's functions, and because the insurance aspects of the warranty business are unique, warranty administrators should be licensed by the Insurance Department.

This comprehensive regulatory structure would place New York in the vanguard of providing protection to both consumers and businesses in regard to warranties.
Senate Bill 2596 (Sen. Velella), Assembly Bill 6281 (Mr. Grannis, Mr. Bianchi, *et al.*)

6. Managing General Agents

To define and prescribe the authority and limitations of persons, firms, associations or corporations acting as reinsurance intermediary brokers, reinsurance intermediary managers and managing general agents.

To bring the penalties applicable to agents, brokers and other licensees into closer relativity to new penalties prescribed for reinsurance intermediaries (RIs) and managing general agents (MGAs).

The press has been replete with horror stories containing examples of abuses by reinsurance intermediaries and managing general agents that have created huge insurer insolvencies. These episodes have not escaped Congressional notice. Congressman John Dingell's widely read report, *Failed Promises*, cited numerous instances in which insurers were brought to ruin by the sharp dealings of unscrupulous reinsurance intermediaries and/or managing general agents. Congressman Dingell introduced H.R. 4900 during the last Congress which would create a federal regulatory agency with authority to regulate the insurance business, including RIs and MGAs.

It cannot be too strongly stressed that the overwhelming number of persons operating as reinsurance intermediaries and managing general agents are honest. This legislation simply promotes responsible business practices. The requirement, for instance, that insurers only engage licensed practitioners and memorialize their business arrangements in writing in the form of a contract is a procedure that no sensible, prudent business person could fault. Similarly, a prohibition against insurers being controlled by directors that are not subject to the Holding Company Act and whose primary loyalty could be to their producer principals, avoids a patent conflict-of-interest situation.

The current Congressional climate, including charges by Congressman Dingell, Senator Metzenbaum and others that States are incapable of effectively regulating the business of insurance, makes it vitally important that New York pass these standards governing the operations of managing general agents and reinsurance intermediaries, among others. This proposal is part of the National Association of Insurance Commissioners (NAIC) accreditation program and failure to enact the proposal can result in New York losing its NAIC accreditation. Such loss would make it more difficult for our domestic insurers to operate in other accredited states. New York must continue its vigilance and leadership in the field of insurance regulation.

Proposed Insurance Law Section 2127 would increase from $500 to $1,000 and from $2,500 to $5,000 certain penalties imposed in lieu of revoking or suspending the license of a licensee under Article 21. It would also authorize the Superintendent to impose a $5,000 fine on reinsurance intermediaries and managing general agents in addition to a license revocation or suspension, and fine insurers up to $5,000 for each violation of the statute. While these increases might at first glance appear to be substantial, the current penalty amounts reflect what were viewed as appropriate levels in 1945 when this Section was first added to the Insurance Law, in 1958 when the $2,500 penalty was added, and in 1977 when the reinsurance intermediary license requirement was enacted in New York. Doubling the amounts merely reflects the value of the 1993 dollar, and avoids a situation where an extremely low penalty is viewed as simply another cost of doing business.
Senate Bill 2601 (Sen. Velella), Assembly Bill 5740 (Mr. Grannis, Mr. Dugan, *et al.*)

7. Confidentiality of Examination Papers

To more adequately protect the confidentiality of work papers and other materials obtained in examinations by providing that they are not subject to subpoena and to permit the Superintendent of Insurance to disclose such materials to state or federal officials and insurance commissioners of other states, provided that these officials are subject to a similar confidentiality law.

The confidentiality provisions in the bill reflect the need for officials in this State and elsewhere to share ofttimes sensitive information on what is increasingly an interstate and international business, without the danger of premature disclosure. This need can only be accomplished if the material that is protected from disclosure under the Freedom of Information Law remains confidential. In the absence of this bill, other jurisdictions can refuse to furnish New York with the information needed to perfect an investigation for fear that such disclosure will jeopardize their own investigations. The increasingly interstate and international nature of the insurance business requires broad and vigilant cooperation in rooting out improper activities. This bill is part of the National Association of Insurance Commissioners accreditation program.
Senate Bill 2822 (Sen. Velella), Assembly Bill 5741 (Mr. Grannis, Mr. Jenkins, *et al.*)

8. Medical Malpractice

(1) To extend to June 30, 1996 (instead of June 30, 1993) the authority of the Superintendent of Insurance to establish medical malpractice insurance rates for physicians.

(2) To amend Section 5504(f) of the Insurance Law to permit the Medical Malpractice Insurance Association (MMIA) to issue policies on an occurrence basis if requested by the insured.

(3) To require the MMIA to submit audited financial statements; and to revise the Insurance Department's MMIA examination schedule by eliminating the current mandate for an annual examination and substituting a requirement for an examination by the Superintendent at least once in every three years or as often as the Superintendent deems it expedient.

(4) To extend to June 30, 1996 (instead of June 30, 1993) the period of time during which the Superintendent of Insurance may not apply for orders of rehabilitation or liquidation of certain domestic insurers whose primary liability arises from the business of medical malpractice insurance, on the grounds of insolvency.

(5) To make a technical amendment updating a June 30, 1993 reference in Section 5502(c) relating to the policy periods used to determine the continued existence of the MMIA.

Bill Section 1 - In the early 1980's, the adverse loss experience of domestic insurers, whose primary liability arose from the business of medical malpractice insurance, placed a severe drain on the surplus of these insurers. In 1985 the Legislature, recognizing the seriousness of the medical malpractice crisis, enacted legislation that was designed to restrain increases in medical malpractice insurance, increase the availability of such coverage, and strengthen the financial condition of insurers writing medical malpractice insurance. Realizing that to have a positive effect the remedies enacted would require time, the Legislature added subsection (c) to Section 2343 of the Insurance Law in order to delay the Superintendent from applying for orders to place these insurers into rehabilitation or liquidation.

Bill Section 2 - The amendment to subsection (c) of Section 5502 is necessary to conform the policy periods for determining surcharges in that section to the June 30, 1994 date that is currently set forth elsewhere in that section.

Bill Section 3 - Section 3436 of the Insurance Law, which had contained similar restrictions on the ability of insurers, other than the MMIA, to issue occurrence coverage for physicians, was amended by Chapter 381 of the Laws of 1991 to permit those insurers to issue both the occurrence and claims-made forms. This bill will conform the provisions in Section 5504(f) applicable to the MMIA to those contained in Section 3436.

Bill Section 4 - The Superintendent is statutorily required to examine the MMIA at least once a year. The interests of the State can be as well served by subjecting the MMIA to the auditing and examination requirements currently applicable to licensed property/casualty insurers. In this way, the MMIA's annual financial statement will be certified by an independent certified public accountant and the Superintendent's examination into the affairs of MMIA, which encompasses both financial matters and other regulatory concerns, can be conducted on a less frequent basis. Under the bill, the Superintendent would reserve the right to examine the MMIA as often as deemed expedient in order to protect the interests of the people of this State.

Bill Section 5 - Medical malpractice insurance for physicians remains a highly volatile market, with the average claim not paid until nine years after it is reported. While rates have moderated recently, it is unlikely that this trend will continue much longer. Therefore, in order to maintain the stability in this market, it is necessary for the Superintendent to continue to establish rates.
Senate Bill 2598 (Sen. Velella), Assembly Bill 6284 (Mr. Grannis, Mr. Gottfried)

9. Article 66 Corporations

To amend Section 6605 of the Insurance Law in order to double the minimum financial, policyholder, and other requirements for newly organized assessment corporations beginning in 1994. This amendment is necessary in order to maintain equality with those property/casualty insurers whose financial requirements were doubled on July 1, 1982.

Also, to amend Section 6608 of such law in order to double the minimum surplus requirements needed by advance premium corporations and assessment corporations wishing to expand their territories.

The amendment to Section 6605 is necessary in order to maintain equality with newly licensed property/casualty insurers whose financial requirements were doubled on July 1, 1982.

The basic financial requirements for newly organized advance premium corporations doubled on July 1, 1982 and the proposed amendment to Section 6605 would, if adopted, double the basic financial requirements for new assessment corporations organized on or after January 1, 1994. The current surplus requirements for expansion of territories of operation by advance premium and assessment corporations have been in effect since 1940 and, therefore, it is also necessary to double the Section 6608 surplus requirements needed by these corporations in order to expand their territories of operation.

Of 35 existing assessment corporations, only two do not meet the amended $200,000 surplus-to-be-maintained requirement. However, the amended grandfather clause in paragraph (3) of subsection (a) of Section 6605 continues to exempt existing corporations from the increased requirements and therefore would only affect these two corporations in the event they intend to expand their territories of operation.
Senate Bill 2597 (Sen. Velella), Assembly Bill 6189 (Mr. Grannis)

10. Article 74: Priority of Distribution of Claims

(a) To amend Article 74 of the Insurance Law (Rehabilitation, Liquidation, Conservation and Dissolution of Insurers) to provide for priority of distribution of assets of an insurer's estate so that every claim in each class shall be paid in full before members of the next class receive any payment.

(b) To clarify Article 74 of the Insurance Law to unequivocally state that the liquidation of an insurance company in New York effects the cancellation of all its policies of insurance, regardless of the provisions of the individual policies.

Priority of Distribution

The distribution of assets of insolvent insurers, with limited exception, is presently made on an equal basis to a number of distinct classes of claimants/creditors. Examples of such classes are:

a. claim and expense payments due various New York security funds;
b. claim and expense payments due various non-New York guaranty funds;
c. federal, state and local taxes;
d. amounts due reinsurers;
e. amounts owing on service and merchandise claims;
f. amounts due claimants, particularly non-New York claimants, for claims in excess of applicable guaranty fund coverage limits;
g. amounts due claimants, particularly non-New York claimants, for claims either excluded from guaranty fund coverage or subject to a guaranty fund deductible.

Prior to making a distribution, it is necessary for the New York Liquidator to identify and quantify each claim in each class so that all claimants may share equally. With respect to certain classes, it is not only difficult and time consuming to do so, it often times is not cost effective.

As an example, a preponderance of non-New York guaranty funds have statutory deductibles of $10 to $200. As a consequence, it is necessary for the New York Liquidator to review tens of thousand of non-New York guaranty fund closed-claim files to identify said deductibles for purposes of including said claim in the distribution. Needless to say, the amounts ultimately distributed to these claimants is far less that the costs involved in making the distribution. Furthermore and of much greater significance is the fact that not only is the distribution process delayed, but many of the checks come back marked "addressee unknown" and must be further traced. Ultimately a good number became subject to the abandoned property law.

Another example is amounts due to reinsurers. While easier to calculate than statutory deductible claims, amounts due reinsurers should not share the same priority as guaranty fund claims. This is particularly so in light of a recent New York court decision that allowed a reinsurer to set off unrelated contract balances. Prior to the court decision it had been the Liquidator's position that offsets were limited within distinct contracts. Since the court has in effect given the reinsurer a partial preference/priority in the assets of the estate (to the detriment of all other claimants and creditors), the reinsurer should not share equally in the remaining assets of the estate.

It is also noteworthy that the other states' receivership laws, as well as the NAIC model act, provide for a priority of payments. This priority enables those states to make distributions much more quickly than New York. This is by virtue of the fact that those other states need only identify and quantify those claimants, beginning with those enjoying the highest priority and working down through the lower priorities, whose claims will be satisfied in full out of available assets. Once this has been done, all other claimants can virtually be ignored. New York on the other hand presently must consider each and every claim in order that a pro-rata distribution be made to all claimants.

The establishment of a priority of payment of claims will not only assist in speeding up the liquidation process, but will also enable the Liquidator to make distributions to the various security funds much more quickly.

Cancellation of Policies

In Matter of Transit Casualty Company (Digirol v. Superintendent of Insurance), 79 N.Y.2d 13 (1992), cert. denied, 61 U.S.L.W. 3261 (October 5, 1992), the New York Court of Appeals, overruling almost a century of New York precedent and disregarding the established rule in virtually every other jurisdiction in this country, determined that an Order liquidating a bankrupt insurance company does not effectively result in the cancellation of that insurance company's policies, unless notice of cancellation is provided in accordance with the provisions of the individual policies. In the course of so ruling, the Court held that the notice and other provisions of the policies are vested prior to liquidation. New York law had always recognized that the policies of a bankrupt insurance company terminate and their value becomes fixed as of the date of liquidation, and that, other than for contingent claims, post-liquidation occurrences are not subject to insurance coverage (Insurance Law Sections 7405(b), 7433; see, e.g., People v. Metropolitan Surety Co., 205 N.Y. 135 [1912]; People v. American Loan & Trust Co., 172 N.Y. 371 [1902]). This was also the rule, and remains the rule, in all other states addressing the issue.

The effect of the Digirol determination is far-reaching and could significantly impact on liquidations in this State and elsewhere. Under this rule, the Superintendent would be required upon liquidation to give notice of cancellation in accordance with the provisions in the statute and the insurance policy, as if the insurer were still "alive." This is not only wasteful of the remaining assets of the liquidated insurer, but may well result in unequal treatment of claimants depending upon the vagaries of policy provisions and how soon an individual insured can be notified given the limited resources available to the Liquidator immediately upon liquidation. Such unequal treatment is anathema to the public policy underlying liquidation.

In fact, immediate termination of all policies is required in liquidation precisely because the insurer is "dead." The State rule governing insurance liquidation should be no different in this respect from the rule applied in a federal court bankruptcy, where executory contracts are voidable by the trustee.

Furthermore, the implication of the Court of Appeals' ruling--that the notice provisions of a policy vest with the insured prior to liquidation--suggests that policies which, by their terms, are not cancelable continue in effect notwithstanding liquidation. Thus, certain forms of bonds and certain life and health coverage would continue notwithstanding the bankruptcy of the company that issued those insuring documents. The result would be a never-ending liquidation process to the great detriment of all claimants. What is more, by the same analysis, the Liquidator might be required to notify insureds that their policies are not to be renewed, since notice of nonrenewal is required under certain circumstances (for example, see

Insurance Law Sections 3425 and 3426 which relate to property/casualty insurance) and the right to such notice might also be deemed vested. The result is an unworkable liquidation process that not only affects the Superintendent's capacity to administer a liquidated estate, but may pose a financial strain on the various New York security funds as well as upon the insureds whose premiums are assessed to build up the fund. Under the Court of Appeals' ruling, the security funds will be liable for post-liquidation occurrences where notice of cancellation (and, perhaps, nonrenewal) was not given in accordance with the provisions of specific policies.

This bill will amend the existing statutes to make clear that the Order of Liquidation terminates all policies of the bankrupt insurer, regardless of their terms or any existing statutory provision, both in the case of a domiciliary state or in the case of the Superintendent's being named Conservator or Ancillary Receiver. The statute already provides significant safeguards to ascertain that notice is provided to all insureds concerning each liquidation. In addition, the Liquidation Order is posted and published. Furthermore, the liquidation of an insurer is hardly a secret--aside from media publicity, insurance brokers obtain such information almost immediately, and are thus in a position to assist insureds in securing appropriate alternative coverage. Any possible prejudice to individuals in particular instances who fail to obtain notice is far outweighed by the enormous prejudice to insureds throughout the State posed by the New York Court of Appeals' Digirol decision.
Senate Bill 2823 (Sen. Velella), Assembly Bill 6191 (Mr. Grannis)

11. Article 59 - Risk Retention Act

(a) To repeal subsection (c) of Section 5906 of the Insurance Law, in order to provide consistency with the related Property/Casualty Insurance Security Fund provisions of Article 76 of the Insurance Law as amended by Chapter 578 of the Laws of 1990; and (b) To repeal the July 1, 1993 sunset provision for Article 59 of the Insurance Law, in order to extend indefinitely the authority bestowed by Chapter 109 of the Laws of 1988, as amended by Chapter 128 of the Law of 1990.

The repeal of subsection (c) of Section 5906 of the Insurance Law, relating to the Property/Casualty Insurance Security Fund protection of purchasing group policies, is necessitated by the subsequent enactment of Chapter 578 of the Laws of 1990 which extended the territorial application of the Property/Casualty Insurance Security Fund, but did not similarly amend Section 5906(c). By removing the specific purchasing group security fund provision in subsection (c) of Section 5906, all security fund coverage questions will be governed solely by Article 76, thereby eliminating potentially inconsistent results.

In addition, the federal Liability Risk Retention Act of 1986 exempts a purchasing group and its members from any law that would discriminate against it. Presently, Section 5906(c) appears to be discriminatory and repeal of this subsection would eliminate this potential problem.

The repeal of the July 1, 1993 sunset provision is necessary to extend indefinitely the authority bestowed by Chapter 109 of the Laws of 1988, as amended by Chapter 128 of the Laws of 1990. This authority is necessary to implement the taxation and limited insurance regulatory powers that the State is permitted to exercise over risk retention groups and purchasing groups operating pursuant to the federal Liability Risk Retention Act of 1986.
Senate Bill 2600 (Sen. Velella), Assembly Bill 6187 (Mr. Grannis)

12. Efficiency of Licensing Bureau Procedures

To amend the term of excess line broker, adjuster and bail bondsmen licenses from one year to two years; to provide statutory authority for the issuance of replacement licenses for lost or destroyed licenses of agents, brokers, excess line brokers, consultants, reinsurance intermediaries and adjusters and to establish a fee therefor; and to exempt broker license candidates holding a Chartered Property Casualty Underwriter (CPCU) designation from prelicensing education and a portion of the qualifying examination requirements.

Renewing excess line broker licenses every two years on the same schedule as the qualifying broker license, and adjuster and bail bond agent licenses every two years as well, will simplify the application process for the licensees while maintaining adequate control on the part of the Department.

The Office of the Comptroller, as part of a 1988 audit of the Insurance Department, strongly recommended the collection of a fee for the issuance of replacement licenses. The Insurance Department concurs with the Comptroller's recommendation and has since 1989 submitted legislation to provide statutory authority for charging a fee.

Currently an applicant for a life and accident and health agent license who holds a Chartered Life Underwriter (CLU) designation is granted an exemption from prelicensing education requirements and a portion of the examination requirements since, in order to qualify for the designation, that person would have been required to successfully complete a series of ten insurance courses related to the life insurance industry.

Likewise, an applicant for a property/casualty agent license who holds a CPCU designation is granted an exemption from prelicensing education requirements and a portion of the examination since, in order to qualify for the designation, that person would have been required to successfully complete a series of ten insurance courses related to the property/casualty insurance industry.

Since the qualifications for the property/casualty agent license and the broker license are very similar, it would appear appropriate to extend the CPCU exemption to broker license candidates as well.
Senate Bill 2603 (Sen. Velella), Assembly Bill 6188 (Mr. Grannis)

13. Excess Line Insurance

To clarify certain provisions regarding placements of insurance with unauthorized insurers by excess line brokers and to permit excess line brokers to procure insurance policies from unauthorized insurers in certain cases where there is an existing residual market facility.

In connection with excess line placements by licensed excess line brokers, this bill would clarify certain aspects of the declination process, including the role of residual market facilities in excess line placements, and provide specific rules as to when the residual market may be bypassed.

An excess line broker must obtain declinations from authorized insurers before the excess line broker may procure an insurance policy from an unauthorized insurer. The excess line broker must make a diligent effort in attempting to obtain insurance from an authorized insurer. The Department has interpreted diligent effort to require that the declinations must come from authorized insurers that the broker has reason to believe might consider writing the risk. A declination from an insurer that is licensed to write a kind of insurance, but does not actually write that type of coverage, is inadequate. This bill would eliminate any further confusion about the Department's interpretation in this area.

This bill also clarifies the role of residual market facilities in excess line placements. Currently, under New York law, there are three residual market facilities that write coverages protecting insureds who are unable to obtain the coverage from the voluntary market: New York Automobile Insurance Plan (NYAIP or Assigned Risk Plan); Medical Malpractice Insurance Association (MMIA); and New York Property Insurance Underwriting Association (NYPIUA), under Articles 53, 54 and 55, respectively.

A longstanding Insurance Department interpretation of the Insurance Law has been that an excess line broker must utilize the appropriate residual market facility when insurance for that insured is available from that facility. This has been a source of considerable disagreement from segments of the insurance industry that have taken the position that a residual market facility should not be considered an insurer and, therefore, need not be canvassed for declinations prior to placement with an unauthorized insurer.

This bill would adjust the existing law by establishing rules for when the residual market facility does not have to be utilized. Residual market facilities would have to be utilized for all liability insurance coverages. It would also have to be utilized for property coverage, unless the insured and any mortgagee that has an interest in the property consent to placement with an unauthorized insurer. In this way, a distinction is drawn between liability coverages, which provide ultimate protection for injured persons, and first party insurance coverages, where the insured can determine the extent of the risk it is willing to bear, while also affording protection to the interests of mortgagees.

This bill also recognizes a longstanding practice in which, after the excess line broker procures the insurance policy, the policy is delivered to the insurance broker with whom the insured initially dealt and this broker, in turn, delivers the policy to the insured. Technically, the broker is in violation of Section 2117 by acting as an unlicensed excess line broker and aiding an unauthorized insurer. The bill would specifically authorize such a broker to deliver the policy to the insured under the circumstances described.

There has also been some confusion as to the scope of the exemption from Section 2117 for any person, firm, association or corporation acting within the scope of the authority conferred by Section 2105, the excess line broker licensing section of the Insurance Law. Some in the insurance industry have viewed this exemption as a blanket exemption from the proscriptions of Section 2117. For example, they believe that an excess line broker may bind coverage for an unauthorized insurer. The Department has narrowly interpreted this provision to exempt an excess line broker from Section 2117 only to the extent authorized by section 2105. In other words, the excess line broker may procure insurance from an unauthorized insurer, but may neither bind nor solicit coverage. This bill would clarify this area.
Senate Bill 4048 (Sen. Velella), Assembly Bill 6190 (Mr. Grannis)

14. Title Insurance

To provide for the licensing of title agents and authorize the Superintendent of Insurance to limit expenses of title insurance companies regarding commissions for the solicitation of title insurance business; and to amend Section 6407 of the Insurance Law in order to require title insurance corporations to comply with the dividend-to-shareholder limitations applicable to property/casualty insurers.

At an Insurance Department public hearing held on February 13, 1991 in order to gather information and elicit comments from experts and interested parties concerning the title insurance industry in New York, speakers, including title agents, unanimously advocated that title insurance agents should be licensed by the Insurance Department.

Title insurers have reportedly experienced increases in the number and severity of agent defalcations in recent years. At the same time, some title insurers have been lax in selecting and policing title agents. Incompetent and, worse, unscrupulous title agents dismissed by one title insurer are apt to be quickly appointed by another title insurer, despite notice of the agent's lack of competence or scruples. If the Insurance Department were given the authority to discipline and remove the license of any agent who violates the Insurance Law or proves otherwise untrustworthy, the incidence of fraud would be reduced.

Licensing would elevate the professionalism and knowledge of title agents and help address controlled business practices. The licensing of title agents will enable the Insurance Department to obtain the information necessary to regulate appropriately all major facets of the title insurance industry. In most cases, title insurance agents receive 80% of the premium dollar in the form of commissions for their services. (The majority of percentage splits between title agents and title companies was 80%-20% according to a Department market survey. Other divisions were 70%-30% and 65%-35%. The overall industry-wide split was 79%-21%.)

In today's market, the title insurance agent has the capability of moving from one title insurance company to another with the business such agent controls. This reality has resulted in what in effect is a bidding war in which a higher and higher percentage of the premium is paid to the agent. As a result, less and less of the premium dollar is retained by the insurer to pay for losses and provide for profits. The health of the title insurance industry has suffered. The payment of up to 80% of the gross premium to the agent, regardless of the price of the property, bears little relationship to the value of the services of the agent. For example, the title insurance policy on a $1 million home does not entail five times the effort required for the search of a $200,000 home. The situation for commercial properties is even more dramatic. Unless the agent is subject to the jurisdiction of the Department by a licensing requirement, however, the Department is effectively unable to require agents to furnish information to the Department.

In a market survey, the Insurance Department attempted to gather title agents' expense data. Only 12 title agents out of a possible 61 ("Top 5" of each company) responded to the Department's request. Currently, there is no way of requiring title agents to disclose to the Department their data on actual expenses in connection with title insurance.

There is a widely felt need in the industry for licensing of title insurance agents who in many cases do all of the work involved in effecting a title insurance policy, such as title searches, clearing titles and filing of documents for the title companies in the issuance of a title policy. The need to assure competency of title agents is demonstrated by the Department's market survey, which indicated that claims and losses turn out to be higher when title agents have been utilized, compared to direct writing experience. The licensing of title agents will permit closer Department supervision of their operations and the elimination of the abuses noted above.

With the ability to gather and analyze the expense data from title insurance agents, the Department will be able to determine the actual costs in delivering a title insurance policy. Moreover, in conjunction with the already existing authority to prior approve rates, the Department will be able to better determine costs, resulting in lower premiums. The authority to establish commission schedules by regulation will relate the actual costs in the title insurance business to the commission level paid to title agents. Unless the Insurance Department is able to review the operations of these agents to the same degree as is the case with property/casualty, life and accident and health agents, the Department will not be able to determine what the appropriate values are of the services provided by title insurance companies and agents.

The existing provisions set forth in Section 6407 of the Insurance Law pertaining to dividends that title insurance corporations may declare and pay to shareholders do not place sufficient restrictions on the amount of dividends that such corporations may pay to shareholders. Provided that a title insurance corporation maintains a stated minimum surplus to policyholders after declaration or payment of a dividend, such an insurer may

declare or pay any such dividend up to the amount of its earned surplus. A title insurance corporation with a large earned surplus may presently declare and pay a dividend in a single year far in excess of the limit applicable to property/casualty insurers without obtaining the prior approval of the Superintendent. Such a depletion in surplus to policyholders could have a detrimental effect on a title insurance corporation. The proposed amendment would require that any proposed dividend be subject to the same standards applicable to property/casualty insurers. In this way the total dividends to shareholders in any single year would be limited to the lesser of 10% of surplus to policyholders or 100% of adjusted net investment income. It should be noted that a greater dividend could be declared with the prior approval of the Superintendent. The current dividend restrictions in Section 6407 make no provision for the Superintendent to approve a dividend that exceeds the prescribed limitations.
Senate Bill 4050 (Sen. Velella), Assembly Bill 7603 (Rules, at the request of Mr. Grannis)

15. Licensing of Multiple Employer Welfare Arrangements

To prohibit multiple employer welfare arrangements (MEWAs) from providing coverage for welfare benefits of any kind to resident employees of employers in this State unless such multiple employer welfare arrangements are authorized by a license in force pursuant to the provisions of the Insurance Law or such benefits are fully insured by a qualified insurer.

Multiple employer welfare arrangements are intended to act as self-insurance pools or as purchasers of group policies from insurance companies for small- and medium-sized (usually unrelated) employers. In theory, MEWAs offer an affordable alternative to conventional coverage. However, in practice, the lack of control or active involvement in the operation and management of MEWAs by participating employers makes such programs particularly susceptible to fraud and abuse.

Some MEWAs are woefully underfunded or outright scams. Prices charged by MEWAs are often 20% to 40% below rates charged by licensed insurers. However, premiums that should be set aside for reserves or to purchase stop loss insurance are diverted to pay extraordinarily high fees for marketing and administration. Some self-funded MEWAs are often no more than elaborate pyramid schemes in which existing claims are paid from the premiums of new enrollees. Unscrupulous MEWA operators have been known to set up self-insured plans for employers, collect premium, and then disappear before paying claims and often before state regulators are aware of their existence.

In recent years, the number of insolvent MEWAs has been increasing. Although precise figures are not available, it is estimated that the total unpaid claims due to failed or failing MEWAs will be in the hundreds of millions of dollars and will affect hundreds of thousands of workers across the nation. The current situation has been compared to the national scandal caused by the collapse of self-funded Multiple Employer Trusts (METs) in the late 1970s and early 1980s that resulted in the 1983 Employee Retirement Income Security Act (ERISA) amendment (P.L.97-473) to limit the effect of ERISA pre-emption on MEWAs.

Unfortunately, the 1983 ERISA amendment did not resolve jurisdictional questions and many MEWAs continue to claim ERISA pre-emption as a defense against state enforcement actions, causing unnecessary delays and further harm. Although the U.S. Department of Labor is conducting civil and criminal investigations on a number of MEWAs and has developed a program to foster cooperation and coordination of enforcement activities with the states, it is generally recognized that a system of prior registration or licensing is required to protect unsuspecting employers and employees from financially unsound and fraudulent arrangements.

The licensing requirement will permit the Department to detect incompetent and fraudulent programs before they begin operation in this State. It will also make MEWAs subject to the same financial, rating, underwriting and reserve requirements and safeguards applicable to other licensed insurers and will ensure that employers purchasing benefits for their employees from such plans or arrangements will be afforded all the protections contained in the Insurance Law.

Although existing statutes relating to unauthorized insurers appear to address some of the problems posed by MEWAs, this bill will put MEWA sponsors on notice before they begin operating in this State that the arrangement must be licensed to do an insurance business. Unauthorized-insurer provisions are useful in closing down operations such as Empire Benefit Plans, Inc. in New York in 1989, but often do not put such programs on notice or permit early detection of poorly managed, financially unsound or fraudulent arrangements. This bill will enhance the protection provided to workers and employees from the injurious effects of financially unsound or irresponsible insurance programs.

It should also be noted that the U.S. Department of Labor has stated in an advisory opinion letter dated July 2, 1990 that state insurance laws may require MEWAs to secure a license or certificate of authority to transact insurance business (ERISA Opinion Letter 90-18A).
Senate Bill 2022 (Sen. Velella), Assembly Bill 6286 (Mr. Grannis, Mr. Jenkins)

16. Registration of Third-Party Administrators

To establish procedures whereby the Insurance Department can obtain basic information concerning third-party administrators of self-funded health benefit programs or trust funds including the identity of third-party administrators and of the plans administered; a statement as to any professional designations or licenses held by the administrator and information as to the method of payment for services rendered to self-funded plans. Through a registration process the Insurance Department will be able to obtain information necessary to understand the nature of, and impact these individuals and organizations have on, self-funded programs and trust funds which now cover a much larger segment of New Yorkers than ever before.

An increasing number of New Yorkers are being covered under self-funded health benefit programs and trust funds. Some aspects of these programs are governed by the provisions of the Employees Retirement Income Security Act; however, there are very limited controls over those who set up and administer these programs. Since the Insurance Law does not now provide for jurisdiction over third-party administrators, there is currently no method available to gather basic information concerning the identity and qualifications of these individuals or firms. The Department is unable to determine the impact that these individuals or firms have on the ultimate success or failure of a self-funded plan. The collection of basic data as provided for in this bill will form the basis of the evaluation of the services being provided and their effect on self-funded programs and the persons covered by such plans. The registration system contemplated by this proposal would provide a level of protection to workers dependent upon this much needed health insurance coverage, helping to ensure that such programs provide the benefits they purport to provide.

This bill is quite narrow in scope. The bill relates only to registration of third-party administrators of self-funded health benefit plans, while earlier proposals would have required registration of self-funded benefit plans and registration of individuals or entities providing administrative services. In addition, under the present bill, insurers licensed to do an insurance business in New York would not be required to meet the registration requirement, but would furnish to the Superintendent required information on a form to be prescribed by the Superintendent.
Senate Bill 4421 (Sen. Velella, Sen. Tully), Assembly Bill 6285 (Mr. Grannis, Mr. Bianchi)

17. Consolidation of Two Security Funds

To consolidate the Public Motor Vehicle Liability Security Fund (PMVLSF) into the Property/Casualty Insurance Security Fund (P/CISF).

The PMVLSF covers victims of accidents involving vehicles for hire (*e.g.*, taxicabs, livery vehicles and buses) where the vehicle was insured by an insurer that subsequently becomes insolvent. The P/CISF covers insurers and claimants under most other nonlife insurance policies issued by property/casualty insurers that become insolvent (with specified exceptions such as title, workers' compensation, mortgage guaranty and health insurance).

PMVLSF's assets have been declining rapidly. The Insurance Department's Liquidation Bureau drew approximately $9.3 million to pay valid claims and expenses from this fund in 1990, more than double the 1989 level of $3.7 million. In 1991, the Liquidation Bureau drew an additional $8.3 million from the fund. By mid-1992, the fund's assets were exhausted and the fund, in order to meet its obligations, was compelled to borrow $2 million from the P/CISF pursuant to Section 7603.

The provisions in present Section 7603(e)(2) that permit the PMVLSF to borrow up to $10 million from the P/CISF will not be sufficient to handle the expected level of current claims. In October 1991, the Department moved in Supreme Court to liquidate American Transit Insurance Company, one of the largest writers of taxicabs and liveries. If the Department's petition (which has been challenged in court) is granted, the insolvency will involve many times the present level of assets in the PMVLSF and will be well beyond the level of contributions that can be obtained from the very limited number of insurers remaining in that fund.

Thus, the consequence of not consolidating the funds would be nonpayment of victims' claims, an intolerable situation. The consolidation provided for in this legislation would spread the burden of future claims payments across a very large liability insurance base and would keep the level of annual assessments to property/casualty insurers within an easily manageable range. Making up any shortfall from the existing PMVLSF would otherwise require a punitive and prohibitive assessment level on insureds purchasing public motor vehicle insurance.

The PMVLSF, whose antecedents were established in 1939, is a creation of an earlier regulatory age, when insurers possessed extremely limited authority and one company could not write a package policy. However, the distinction between fire, marine, casualty and surety companies was gradually eroded in later decades and finally eliminated with the Insurance Law recodification in 1984 and the consequent authorization of a property/casualty insurer that combined all these types of insurance into one entity. Therefore, the existence of the PMVLSF as a separate entity is outdated.

In the interest of equity, the bill provides that for the next five years, there will be a special assessment on public motor vehicle liability insurance business of 3% of premium for such business, which is the current rate of assessment in the PMVLSF. This assessment will be in addition to any assessments that may be required of all insurers of liability business in the P/CISF.
Senate Bill 2594 (Sen. Velella), Assembly Bill 6283 (Mr. Grannis, Mr. Bianchi)

18. Acquisition of Insurance Company Shares

To amend Section 1408 of the Insurance Law to extend the existing limitation on the acquisition of insurance company shares to any type of investment (*e.g.*, bonds) in other insurance companies; to amend Section 1411(e) of the Insurance Law to extend restrictions on the valuable consideration a director or officer may receive for the lease of property by an insurer; and to amend Section 6507 of the Insurance Law to make conforming amendments in references to Article 14.

The existing provisions set forth in Section 1408 of the Insurance Law pertaining to investments by property/casualty insurers in insurance companies fail to take into account other types of investments that increase the amount an insurer may have invested in other insurance companies. Such investments should be included when calculating the statutory limitation, and accordingly the revision extends the limitation to any investment in other insurance companies.

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The existing provisions set forth in Section 1408 of the Insurance Law pertaining to investments by property/casualty insurers in insurance companies fail to take into account other types of investments that increase the amount an insurer may have invested in other insurance companies. Such investments should be included when calculating the statutory limitation, and accordingly the revision extends the limitation to any investment in other insurance companies.

The same restrictions that are currently set forth in subsection (e) of Section 1411 relating to the sale or purchase of property should also be extended to the leasing of property by an insurer. An officer or director of an insurer should not receive valuable consideration, over and above the fixed salary or compensation, for arranging or participating in a transaction involving real estate, whether it involves the sale or purchase of real property, or leaseholds.

The cross-references to provisions of Article 14 set forth in Section 6507 require a technical conforming revision due to changes to Article 14 enacted in Chapter 324 of the Laws of 1992. In addition, the repeal of item (iii) of Section 1404(a)(4)(C) is made for purposes of clarification since subparagraph (C) was repealed by Chapter 324.
Senate Bill 2909 (Sen. Velella), Assembly Bill 6278 (Mr. Grannis, Mr. Brennan)

19. Enhanced Consumer Access to Automobile Insurance

To enhance consumer access to private passenger automobile insurance in this State by requiring all authorized property/casualty insurers writing such insurance to establish and maintain a toll-free telephone line for consumers to obtain the names, business addresses and telephone numbers of producers and sales offices, conveniently located to the consumer, authorized to accept applications on behalf of the insurer.

Private passenger automobile insurance is generally available and affordable in this State. Many insurers actively seek to write such business in New York. Consumers who need automobile insurance may not always know how best to access these insurers. By the toll-free telephone line requirement, this bill would create an easy and practical way for insurers and consumers to match supply and demand regarding automobile insurance. At the same time, the bill respects the vital role played by insurance agents and brokers throughout the State.

Some insurers writing private passenger automobile insurance publish their own names, addresses and telephone numbers in local directories, but do not, even when requested by a consumer, identify the names of producers who are conveniently located to the consumer and authorized to accept applications for insurance.

The bill recognizes that insurers need to engage in sound underwriting, that insurers may market coverage in different ways, and that insurers utilizing agents or brokers may not have a producer in every territory of the State.

Providing consumers greater information and easing access to automobile insurers is a feasible, cost-effective approach to fostering an informed and competitive marketplace. This bill would facilitate the ability of consumers to more readily obtain automobile insurance at the most competitive prices.

By enhancing consumer access to automobile insurance, these measures will also help reduce the size, or depopulate, the Assigned Risk Plan. Depopulation was the subject of a public hearing held in September 1992 by the Senate Insurance Committee.
Assembly Bill 6279 (Mr. Grannis, Mr. Lafayette)

20. Article 24: Unfair Method of Competition

To eliminate a certain exemption granted to insurers whose rates are subject to prior rate approval, and to amend Article 24 of the Insurance Law in order to give the Superintendent of Insurance greater flexibility in responding to violations of the Insurance Law.

The proposal to amend Section 2316(c) of the Insurance Law aims to correct an anomaly in deterring and remedying anti-competitive conduct by insurers as to certain kinds of insurance. Under current Section 2316(c) those insurers whose coverages entail prior rate approval under Section 2305(b)--including such key coverages as workers' compensation, title insurance and medical malpractice insurance--are exempt, as to those coverages, from the specific proscriptions in Section 2316(a) and are thereby immune from liability or injunctive relief in a private treble-damage suit or an action by the Superintendent through the Attorney General under Section 2316(b), as to those coverages. Yet, private passenger automobile insurers, credit life insurers, and Article 43 corporations offering health insurance are all subject to such proscriptions and remedies, notwithstanding that rates for such coverages require prior approval. Apart from insurance activities of a joint or collective nature, which the Legislature has already authorized, such as joint underwriting, automobile assigned risk insurance, risk sharing plans under Section 2318, and insurance issued by such joint underwriting associations, there is nothing inherent in title insurance, workers' compensation insurance, mortgage guaranty insurance, medical malpractice insurance or credit property insurance that would justify the current exemption to achieve efficient and stable markets. The bill does not change the existing exemption for joint and collective activities in Section 2305(b) that have been legislatively sanctioned.

Because of its limitations and cumbersome procedures, Article 24 is rarely used by the Insurance Department and, therefore, has not served its intended purpose of deterring unlawful insurance activities. The proposed amendments would help to correct this by making the statute a much more effective tool in preventing and promptly halting serious violations of the Insurance Law.

By expanding the list of defined violations to include many significant violations of the Insurance Law that are currently not mentioned, the Superintendent's effectiveness in enforcing the law and protecting the consumer would be greatly enhanced.

As described above in the section on existing law, the procedure after report on determined violations under Section 2407 does not allow for effective enforcement of the law. Under Section 327 of the Insurance Law the Superintendent, through the Attorney General, can already proceed in court to obtain an injunction against a violation of the Insurance Law regardless of whether a hearing under Section 2405 has been held. The current procedure for the enforcement of a finding of a determined violation adds nothing but another optional layer of procedure (a Section 2405 hearing) to the enforcement protocol that the Superintendent must follow in any event.

The Superintendent's ability to promptly halt illegal insurance activities would be greatly enhanced by giving the Superintendent the power to issue a cease and desist order following hearings as to both defined and determined violations of Article 24. The proposed amendments would eliminate the cumbersome and ineffective enforcement procedure for determined violations that is currently provided, as described above.

Under Section 2406(d) a cease and desist order is final upon the expiration of the time allowed for commencing a proceeding for judicial review if no proceeding has been commenced within that time, or upon the final decision of the reviewing court affirming the order or dismissing the proceeding. The monetary penalty imposed under Section 2406(e) does not accrue until a cease and desist order becomes final. The proposed elimination of the period until the order becomes final would make the Superintendent's power to issue cease and desist orders more effective. In order to serve as a meaningful deterrent, penalties for violations should accrue from the time the order is served. This, however, would not apply to an order that is voluntarily withdrawn or stayed by a court.

The proposal to give the Superintendent limited power to issue summary cease and desist orders prior to hearing is consistent with the laws of New York and several other states. In New York, for example, under Section 36 of the Agriculture and Markets Law the Commissioner of Agriculture and Markets can before a hearing, if it be ascertained that any person has failed to comply with or is guilty of a violation of the law or a Department rule, issue an order compelling compliance. Other states, including Arkansas, California, Connecticut, Kansas, Missouri, North Dakota, Oregon and Texas, have statutes granting their insurance commissioners similar authority under various specified circumstances.

The power to issue a summary cease and desist order is essential to carry out the statutory obligation placed upon the Superintendent to enforce the Insurance Law. Effective enforcement often requires that swift action be taken to halt illegal activity in order to avoid or minimize harm to the public.

Due process rights of a person affected by a summary cease and desist order would be protected under the bill. The person served with the order would at the same time be served with a statement of charges and notice of hearing. The hearing must be held within ten days of the service of the notice of hearing unless the person agrees to a later date. The person may also make written application at any time for relief from the summary cease and desist order.

Section 401(3) of the State Administrative Procedure Act (SAPA) does not provide complete remedial power since it relates solely to the suspension of a license. The mere suspension of a license would not prevent the commission of an illegal activity. Moreover, the suspension of a license is an extreme action. The issuance of a summary cease and desist order against a licensee would be a much less severe and a more precisely targeted remedy than the summary suspension of a license. A licensee against whom a summary cease and desist order is issued would still be able to pursue its ordinary business activities, other than those specifically affected by the order.
Senate Bill 2795 (Sen. Velella), Assembly Bill 6186 (Mr. Grannis)

21. Group Health Insurance: Updating and Clarification of Provisions

The general purpose of this proposal is to update and clarify certain provisions of the Insurance Law concerning health insurance. Under this proposal it is made clear that commercial insurers cannot terminate conversion coverage on insureds who are covered by or eligible for Medicare by reason of disability. Statutory conversion benefits of commercial insurers have been increased and revised and certain conversion rate computations for persons age 60 and over must be recalculated in accordance with the requirements of community rating. Also this legislation would expand State requirements to more closely conform to federal requirements with regard to the continuation rights of individuals under group medical coverage issued by Article 43 corporations.

The change of Section 1 that would not allow commercial insurers to terminate conversion coverage of insureds when eligible for Medicare for reasons other than age would aid insureds from being inappropriately terminated from needed conversion coverage on the basis of supposed overinsurance. Some commercial insurers desire to terminate insureds from conversion coverage because such insureds can obtain or do obtain Medicare before age 65 due to disability. Yet the Medicare coverage often leaves the insured with balances to pay after Medicare pays its benefits. Present Insurance Department regulations permit insurers to have language in conversion coverage that allows the insurer to only pay the excess of charges not paid by Medicare. Therefore, overinsurance does not really exist as claimed by some insurers, and insurers have the ability to protect themselves from duplicating the payment of Medicare benefits. This change allows insureds with conversion coverage to keep it so that the private conversion coverage can pay any excess charges not paid by Medicare when the insured is or could be covered by Medicare before age 65.

The change of Section 2 simply puts commercial insurers on notice that the specific rating practice stated in Section 3221(f) of the Insurance Law must be interpreted to be consistent with open enrollment and community rating requirements for individual and small group conversion coverages. Conversion coverage may be available on an individual or small group basis and the open enrollment and community rating requirements elsewhere in the Insurance Law apply to such individual or small group coverages when they provide conversion coverage mandated by Section 3221. This change will clarify this applicability of open enrollment and community rating.

The changes of Section 3 that amend subsection (g) of Section 3221 of the Insurance Law are needed to update statutory base conversion coverage benefits. These benefits were last increased in 1986 and due to inflation require these changes so that a convertee has meaningful coverage to pay his/her health care costs.

The changes of Section 4 that amend subsection (h) of Section 3221 of the Insurance Law are needed to update statutory major medical conversion coverage benefits. These benefits were last increased in 1986 and due to inflation require these changes so that a convertee has meaningful coverages to pay his/her health care costs.

The changes of Section 5 that amend paragraphs (1), (2), (3) and (4) of subsection (e) of Section 4305 of the Insurance Law are necessary to change State continuation requirements for Article 43 group insurance coverages to more closely resemble continuation requirements of federal law (Consolidated Omnibus Reconciliation Act of 1985 - COBRA). Presently an Article 43 group insurance plan subject to Section 4305 of the Insurance Law which is issued to a policyholder subject to federal law (e.g., employer of 20 or more employees) will contain the generally more generous continuation rights of COBRA than the same group insurance plan issued to a policyholder subject to state law (e.g., employer of fewer than 20 employees). The changes in Section 5 of this bill will make such continuation rights under State law virtually identical to federal law. Also the changes of Section 5 will make State continuation rights for group plans of Article 43 corporations identical to State continuation rights mentioned in Section 4304 of the Insurance Law for group remittance plans of Article 43 corporations. There is no logical reason for a difference, and the changes in Section 5 should have been made under Chapter 501 of the Laws of 1992. In this respect the changes in Section 5 are also technical corrections to make Sections 4305(e)(1)(2)(3)(4) agree with the continuation rights that must be granted by commercial insurers due to changes in Sections 3221(m)(1)(2)(3)(4) already enacted in Chapter 501 of the Laws of 1992.
(Senate Bill 4735 (Sens. Velella, Tully), Assembly Bill 7777 (Rules, at the request of Mr. Grannis)

22. Cumulative Penalties for Failure to File Reports on Timely Basis

To provide for cumulative penalties for an insurer's failure to file on a timely basis any special reports as may be required by the Insurance Law.

Various legislative enactments over the past few years require that reports be provided to the Governor and the Legislature. For example, Insurance Law Section 334, as implemented by Regulation 131 (11 NYCRR 162), requires that an annual commercial property/casualty insurance report be prepared and furnished to the Governor and the Legislature. Insurance Law Section 3425 requires that insurers furnish annual statistical reports to the Superintendent and that the statistics be summarized, compiled and analyzed in reports to the Legislature, as required.

Timely submission of data by insurers is crucial in order to ensure that required reports to the Superintendent and the Governor and Legislature are meaningful. Some insurers submit these required reports too late to include their data in these reports, diminishing the utility of the reports.

In order to impress upon insurers the importance of timely submission of required reports to the Superintendent, the Department had been imposing penalties upon insurers based on tardiness in filing. The Department considered each day of lateness to be a separate offense and interpreted Insurance Law Section 109 to allow up to $500 per day for each day of lateness. While the Department believed that a maximum of $500 per day could be imposed for each day of lateness, the Department has never imposed the maximum amount. Instead, the Department had been applying graduated penalties based upon degree of lateness of the required report.

In American Transit Ins. Co. v. Corcoran, 76 N.Y.2d 977, 56 N.Y.S.2d 736 (1990), the Court of Appeals ruled that failure to file a required form by a specified date constitutes one offense under Section 109, regardless of the number of days the required form was late, because there is no authority to impose a penalty for each day's lateness in filing as an additional violation. The Court of Appeals noted that "...treating continuing violations as separate daily transgressions, has been upheld only where cumulative penalties are expressly authorized by statute," such as the Insurance Law Section 307(a)(4) cumulative penalty provisions. Under this decision's interpretation of current law, a willful delay of more than seven months, as occurred in that case, can be penalized by a mere $500.

Enactment of this bill would put insurers on notice that failure to submit required reports on time is a serious infraction. Insurers must not be able to simply write off the penalty as a relatively minimal cost of doing business and ignore the requirements of the statute. The Department's inability to impose a maximum penalty of more than $500 on an insurer, regardless of the insurer's lateness in filing, strips statutory reporting requirements and the required reports themselves of their intended value.
Senate Bill 2602 (Sen. Velella), Assembly Bill 6280 (Mr. Grannis, Mr. Brennan, et al.)

23. Managed Care - No-Fault Insurance

To reduce the costs and enhance the quality of medical and other health care services applicable to motor vehicle no-fault insurance policyholders, covered persons, insurers and self-insurers by providing managed care alternatives for delivery of such services.

Due to the ever increasing medical and health care costs, it has become necessary to attempt to contain these unabated costs before no-fault motor vehicle insurance becomes unaffordable. This legislation preserves the common goals of providing reasonable and meaningful health care protection at an affordable price while emphasizing quality care. Implementation of managed care programs for no-fault coverage will provide quality care at the lowest cost through coordination of treatment and greater accountability of providers of health care services to payers of those services. Insurers will also be able to improve insurance cost containment efforts through negotiating medical costs and payments with health care service providers.

The health care cost crisis is a subject of nationwide concern. Innovative approaches to attempt to solve the problems in the present system must be explored and given sufficient time to prove their value. The managed care alternatives to be permitted by this bill create opportunities for a variety of thoughtful and practical approaches that both providers of health care services and those that pay for such services can initiate in cooperative efforts to bring better order and control to the health care cost spiral.

In Colorado, for example, legislation was passed to allow insurers to sell automobile insurance policies with an option to receive medical health benefits through a managed care facility. Those choosing this type of coverage had their premiums reduced by as much as 8 to 12% below the standard auto insurance policy.
Senate Bill 4715 (Sens. Velella, Tully), Assembly Bill 6277

IV. REGULATORY ACTIVITIES

A. OPERATING STATISTICS

1. Summary of Statistical Tables

Table 58 - Part I
SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT
SELECTED BALANCE SHEET DATA

(dollar amounts in millions)

	No. of Cos.	Admitted Assets	Liabilities	Surplus and Capital Funds
		TOTAL - ALL LICENSED COMPANIES[a]		
TOTAL - All Licensed Companies	949	$1,455,655	$1,270,563	$185,091
Property/Casualty	649	483,755	351,514	132,240
Life[b]	146	921,600	878,242	43,358
Accident & Health	17	3,787	2,625	1,163
Fraternal	51	29,368	26,672	2,696
Health Service and Medical & Dental Indemnity Corps.[c]	14	4,148	3,725	422
Health Maintenance Organizations[c]	30	667	474	193
Title	19	1,525	1,038	487
Mortgage Guaranty	12	4,052	2,520	1,532
Financial Guaranty[d]	11	6,753	3,753	3,000

See footnotes at end of table.

Table 58 - Part I (Continued)
SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT
SELECTED BALANCE SHEET DATA

(dollar amounts in millions)

	No. of Cos.	Admitted Assets	Liabilities	Surplus and Capital Funds
		NEW YORK STATE DOMICILED COMPANIES		
TOTAL - N.Y. Domiciled Companies	364	$394,011	$364,066	$29,944
Property/Casualty	199	53,707	42,838	10,868
Stock	127	38,648	29,154	9,493
Mutual	20	13,681	12,697	984
Advance Premium Co-op.	19	567	383	184
Lloyds & Reciprocal	5	667	545	122
Assessment Co-op.	28	144	59	85
Life[b]	88	330,398	314,074	16,324
Accident & Health	10	115	71	45
Fraternal	8	91	78	13
Health Service and Medical & Dental Indemnity Corps.[c]	14	4,148	3,725	422
Health Maintenance Organizations[c]	30	667	474	193
Title	9	184	92	92
Financial Guaranty[d]	6	4,701	2,714	1,987

See footnotes at end of table.

Table 58 - Part I (Concluded)
SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT
SELECTED BALANCE SHEET DATA

(dollar amounts in millions)

	No. of Cos.	Admitted Assets	Liabilities	Surplus and Capital Funds
OTHER STATES' DOMICILED COMPANIES				
TOTAL - O.S. Domiciled Companies	556	$1,049,733	$897,818	$151,914
Property/Casualty	422	421,088	302,413	118,674
Stock	368	314,507	233,830	80,677
Mutual	51	98,801	64,221	34,579
Reciprocal	3	7,780	4,362	3,418
Life	58	591,202	564,168	27,034
Accident & Health	7	3,672	2,554	1,118
Fraternal	42	26,326	24,178	2,148
Title	10	1,341	946	395
Mortgage Guaranty	12	4,052	2,520	1,532
Financial Guaranty[d]	5	2,052	1,039	1,013
ALIEN DOMICILED COMPANIES				
TOTAL - Alien Domiciled Companies	29	$11,911	$8,679	$3,233
Property/Casualty	28	8,960	6,263	2,698
Fraternal	1	2,951	2,416	535

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[a] Figures may not add due to rounding.

[b] Includes transactions of Savings Bank Life Insurance departments, which are counted as one company.

[c] There are six health service corporations that contain health maintenance organizations (HMOs) as a line of business. These corporations do not segregate the balance sheet data (assets, liabilities and surplus) of their HMOs. Such data are, therefore, included in the Health Service rather than the HMO category.

[d] Financial guaranty insurance, prior to 1989, was included with data for property/casualty companies.

NOTE: Excludes 13 public and private pension funds and 8 variable supplements funds.

Table 58 - Part II
SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT PREMIUMS AND LOSSES

(dollar amounts in millions)

		Total Business (Net)		New York State Business (Direct)	
	No. of Cos.	Premiums Written	Losses Paid	Premiums Written	Losses Paid
ALL LICENSED COMPANIES[a]					
TOTAL - All Licensed Companies	949	$340,136	$247,227	$55,163	$40,378
Property/Casualty	649	169,256	105,642	19,818	11,274
Life[b]	146	146,799	124,786	20,730[c]	15,998[c]
Accident & Health	17	2,918	2,001	237	139
Fraternal	51	3,945	1,443	106	42
Health Service and Medical & Dental Indemnity Corps.[d]	14	11,299	10,638	11,299	10,638
Health Maintenance Organizations[d]	30	2,511	2,253	2,511[e]	2,253[f]
Title	19	1,805	142	210	21
Mortgage Guaranty	12	944	316	63	9
Financial Guaranty[g]	11	659	6	179	4

See footnotes at end of table.

Table 58 - Part II (Continued)
SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT
PREMIUMS AND LOSSES

(dollar amounts in millions)

	No. of Cos.	Total Business (Net)		New York State Business (Direct)	
		Premiums Written	Losses Paid	Premiums Written	Losses Paid
NEW YORK STATE DOMICILED COMPANIES					
TOTAL - N.Y. Domiciled Companies	364	$76,084	$65,632	$29,449	$26,045
Property/Casualty	199	14,820	8,158	5,525	2,772
Stock	127	11,108	6,137	2,420	1,225
Mutual	20	3,200	1,782	2,495	1,272
Advance Premium Co-op.	19	318	165	415	205
Lloyds & Reciprocal	5	140	47	127	34
Assessment Co-op.	28	54	27	68[h]	36[h]
Life[b]	88	46,706	44,511	9,749	10,308
Accident & Health	10	84	52	102	62
Fraternal	8	8	5	7	3
Health Service and Medical & Dental Indemnity Corps.[d]	14	11,299	10,638	11,299	10,638
Health Maintenance Organizations[d]	30	2,511	2,253	2,511[e]	2,253[f]
Title	9	178	13	112	9
Financial Guaranty[g]	6	478	2	144	*

* Less than 0.5

See footnotes at end of table.

Table 58 - Part II (Concluded)

SUMMARY OF STATISTICAL TABLES AS OF DECEMBER 31, 1991 - PRIOR TO AUDIT PREMIUMS AND LOSSES

(dollar amounts in millions)

	No. of Cos.	Total Business (Net)		New York State Business (Direct)	
		Premiums Written	Losses Paid	Premiums Written	Losses Paid
		OTHER STATES' DOMICILED COMPANIES			
TOTAL - O.S. Domiciled Companies	556	$260,952	$180,069	$25,427	$14,208
Property/Casualty	422	151,674	96,100	14,019	8,378
Stock	368	107,715	67,338	11,375	6,743
Mutual	51	40,575	26,726	2,540	1,578
Reciprocal	3	3,384	2,036	104	57
Life	58	100,093	80,275	10,981	5,690
Accident & Health	7	2,834	1,949	135	77
Fraternal	42	3,599	1,296	96	38
Title	10	1,627	129	98	12
Mortgage Guaranty	12	944	316	63	9
Financial Guaranty[g]	5	181	4	35	4
		ALIEN DOMICILED COMPANIES			
TOTAL - Alien Domiciled Companies	29	$3,100	$1,526	$277	$125
Property/Casualty	28	2,762	1,384	274	124
Fraternal	1	338	142	3	1

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[a] Figures may not add due to rounding.

[b] Includes transactions of Savings Bank Life Insurance departments.

[c] Includes annuity and other fund deposits. Such figures have been included in "Total Business" since the Annual Statement began showing them on Page 46 in 1983. The figures are (in millions of dollars): 1983, $178; 1984, $362; 1985, $1,359; 1986, $1,860; 1987, $3,494; 1988, $5,508; 1989, $3,417; 1990, $5,831; 1991, $6,013.

[d] Data are for all health maintenance organizations (HMOs), including six that are a line of business of health service corporations. HMO premium ($1,723 million) and loss data for these line-of-business HMOs have been excluded from health service corporation data.

[e] Net premium income (earned).

[f] Losses incurred.

[g] Financial guaranty insurance, prior to 1989, was included with data for property/casualty companies.

[h] Not comparable to years prior to 1988 when "net" rather than "direct" figures were published.

NOTE: Excludes 13 public and private pension funds and 8 variable supplements funds.

2. Results of Examinations for Licenses

Table 59
RESULTS OF EXAMINATIONS FOR LICENSES
Adjusters, Agents, Brokers and Consultants
1991 and 1992

	1992		1991	
Type of Examination	Number Taking Examination	Percent Passing	Number Taking Examination	Percent Passing
Total	29,758	68%	27,935	66
Public Adjusters	144	28	133	33
Independent adjusters - total	783	57	636	71
Accident & health	24	21	14	64
Automobile	180	43	91	54
Aviation	-0-	-0-	4	50
Casualty	243	68	120	78
Fidelity and surety	2	50	-0-	-0-
Fire	42	50	49	51
General (all lines)	160	51	149	50
Health service charges	-0-	-0-	-0-	-0-
Inland marine	15	7	21	14
Limited auto (damage or theft appraisals only)	117	83	188	79
Agents - total	25,483	68	23,801	68
Accident & health	11,610	64	10,746	66
Life and SBLI	12,364	71	11,396	71
Mortgage guaranty	1	-0-	1	100
General agent (P&C)	1,501	76	1,649	64
Bail bond	7	57	9	56
Credit	-0-	-0-	-0-	-0-
Brokers	3,348	67	3,361	51
Consultants - total	1	-0-	4	75
General	-0-	-0-	3	66
Life	1	-0-	1	100

Table 60
LICENSES ISSUED DURING YEAR
1991 and 1992

	1992	1991
Total	64,155	111,295
Adjusters[a]		
Independent Renewable annually January 1 under Section 2108(c)	3,296	2,330
Public Renewable annually January 1 under Section 2108(c)	741	521
Agents[b]		
Life and Accident and Health Renewable biennially as of July 1 of odd-numbered years under Section 2103(a)	13,002	82,330
Savings Banks Life Cert. Holders Perpetual under Section 2203	437	557
Fire, Casualty, Fidelity & Surety Renewable biennially as of July 1 of even-numbered years under Section 2103(b)	22,879	2,337
Rental Vehicle Renewable biennially as of July 1 of even-numbered years under Section 2131	41	21
Mortgage Guaranty Insurance Perpetual under Section 6505	0	5
Bail Bond[a] Renewable annually January 1 under Section 6802(c)	106	54
Brokers[c]		
Excess Line[a] Renewable annually November 1 under Section 2105	494	430
Regular Renewable biennially November 1 under Section 2104	22,196	21,751

Consultants[d]		
Life Insurance Consultant Renewable annually April 1 under Section 2107	261	267
General Insurance Consultant Renewable annually April 1 under Section 2107	404	395
Reinsurance Intermediaries Renewable annually September 1 under Section 2106(a)	298	297

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[a] Excess line brokers, adjusters, and bail bond agents are licensed on an annual basis: excess line brokers as of November 1; adjusters and bail bond agents as of January 1.

[b] Agents for life, annuities and accident & health insurance are renewable biennially as of July 1 of odd-numbered years. Property and casualty agents are renewable biennially as of July 1 of even-numbered years. Section 2203 SBLI Certificate Holders and Section 6505 agents are licensed on a perpetual basis.

[c] Brokers are renewable biennially as of November 1 of the odd or even year according to which of the two groups the licensee has been assigned.

[d] Consultants are renewable annually as of April 1.

[e] Reinsurance intermediaries are renewable annually as of September 1.

3. Changes in Status of Authorized Insurers During 1992

a. Life Insurance Companies

Domestic Companies Incorporated

First North American Life Assurance Company, County of Westchester, NY	Feb. 10
First Xerox Life Insurance Company, New York, NY	Dec. 31

Domestic Companies Licensed

Empire Fidelity Investments Life Insurance Company, New York, NY	May 20
First North American Life Assurance Company, Rye, NY	July 22

Restated Charters Filed

The Amalgamated Life Insurance Company, Inc., New York, NY	Jan. 28
Washington National Life Insurance Company of New York, New York, NY	Apr. 28

Amendments to Charter Filed

American Western National Life Insurance Company, New York, NY	Jan. 6
Financial Security Life Insurance Company, Syracuse, NY	Jan. 27
First Investors Life Insurance Company, New York, NY	June 19
American Mayflower Life Insurance Company of New York, New York, New York	Aug. 7
Bankers Life and Casualty Company of New York, Garden City, NY	Sept. 8
Canada Life Insurance Company of New York, Harrison, NY	Sept. 16
Bankers Life and Casualty Company of New York, Garden City, NY	Dec. 10

3. Changes in Status of Authorized Insurers During 1992

a. Life Insurance Companies
(continued)

Changes of Name

"American Western National Life Insurance Company" to "First Central National Life Insurance Company of New York," Lynbrook, NY	Jan. 6
"Financial Security Life Insurance Company" to "First Fortis Life Insurance Company," Syracuse, NY	Jan. 27
"The Amalgamated Life Insurance Company, Inc." to "Amalgamated Life Insurance Company," New York, NY	Jan. 28
"Federated Investors Life Insurance Company" to "American Combined Life Insurance Company," Lincoln, NE	Mar. 25
"Phoenix Mutual Life Insurance Company" to "Phoenix Home Life Mutual Insurance Company," East Greenbush, NY	July 1

Change in Capital Structure

The Amalgamated Life Insurance Company, Inc., New York, NY (from $1,000,000 to $2,000,000)	Jan. 28

Change in Authorized Capital

The Amalgamated Life Insurance Company, Inc., New York, NY (from $1,000,000 to $2,000,000)	Jan. 28

Merger Agreement Filed

Home Life Insurance Company, of New York, NY into Phoenix Mutual Life Insurance Company, Hartford, CT	July 1

3. Changes in Status of Authorized Insurers During 1992

a. Life Insurance Companies
(concluded)

First Charter Life Insurance Company, of New York, NY into Intramerica Life Insurance Company Pearl River, NY	Nov. 1
United Mutual Life Insurance Company, New York, NY into Metropolitan Life Insurance Company, New York, NY	Dec. 29

Redomestications

Phoenix Mutual Life Insurance Company, of Hartford, CT from Connecticut to New York	July 1
Credit Life Insurance Company, of Springfield, OH from Ohio to Illinois	July 23

b. Accident and Health Insurance Companies

Change of Name

"Bankers Assurance Company" to "Ameritas Bankers Assurance Company," New City, NY	Oct. 1

Amendments to Charter Filed

Oxford Health Insurance, Inc., New York, NY	Sept. 24
Bankers Assurance Company, New City, NY	Oct. 1

Change in Authorized Capital

Oxford Health Insurance, Inc., New York, NY ($300,000 to $500,000)	Sept. 24

3. Changes in Status of Authorized Insurers During 1992

c. Not-For-Profit Health Service Corporations

Consent to Filing of Certificate of Incorporation

Preferred Assurance Company, Inc., County of Monroe, NY	Mar. 27
Preferred Assurance Company, Inc., County of Albany, NY	May 29
MVP Health Services Corp., Schenectady, NY	Aug. 4

Domestic Companies Licensed

Preferred Assurance Company, Inc. Rochester, NY	Aug. 6
Health Services Medical Corporation of Central New York, Baldwinsville, NY	Oct. 1

d. Savings Banks (Life Insurance Department)

Changes of Name

"The Home Savings Bank" to "Home Savings of America, SSB," Bayside, NY	Apr. 20
The Bowery Savings Bank" to "Home Savings of America, The Bowery Div., SSB," New York, NY	Apr. 20

e. Property and Casualty Insurance Companies

Domestic Companies Incorporated

Alerion Insurance Company, County of Nassau, New York	Feb. 10
Folksamerica National Reinsurance Company, County of New York, NY	Feb. 10
Greater United Insurance Company, County of New York, NY	Mar. 5
Paragon Insurance Company of New York, County of Suffolk, NY	Sept. 28

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (continued)

Domestic Companies Licensed

Alliance Assurance Company of America, New York, NY	Jan.	1
The London Assurance of America, Inc., New York, NY	Jan.	1
Sun Insurance Office of America Inc., New York, NY	Jan.	1
The Sea Insurance Company of America, New York, NY	Jan.	1
Contractors Casualty and Surety Company, Staten Island, NY	Mar.	19
Folksamerica National Reinsurance Company, New York, NY	Mar.	31
Lloyds New York Insurance Company, New York, NY	July	1

Foreign Companies Licensed

Capital Reinsurance Company, Baltimore, MD	Jan.	15
Star Insurance Company, Southfield, MI	Mar.	19
Commercial Union Midwest Insurance Company, Brookfield, WI	May	26
Empire Fire and Marine Insurance Company, Omaha, NE	July	8
Criterion Casualty Company, Chevy Chase, MD	July	9
Continental National Indemnity Company, Cincinnati, OH	Sept.	9

Domestication Agreements

Alliance Assurance Company, Limited, London, England into Alliance Assurance Company of America, New York, NY	Jan.	1
The London Assurance, London, England into The London Assurance of America Inc., New York, NY	Jan.	1
Sun Insurance Office Limited, London, England into Sun Insurance Office of America Inc., New York, NY	Jan.	1

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (continued)

The Sea Insurance Company Limited, London England and The Sea Insurance Company of America, New York, NY	Jan. 1

Amendments to Charter Filed

American Independent Reinsurance Company, New York, NY	Jan. 8
Hermitage Insurance Company, White Plains, NY	Jan. 28
Exchange Insurance Company, Buffalo, NY	Feb. 7
United Reinsurance Corporation of New York, New York, NY	Mar. 11
Contractors Casualty and Surety Company, Hicksville, NY	Mar. 19
Farm Family Mutual Insurance Company, Glenmont, NY	Mar. 25
American International Insurance Company, New York, NY	Mar. 30
American National Fire Insurance Company, New York, NY	May 5
Unione Italiana Reinsurance Company of America, Inc. New York, NY	May 11
Eveready Insurance Company, Brooklyn, NY	June 5
Paladin Reinsurance Corporation, New York, NY	July 1
Gerling America Insurance Company, New York, NY	July 14
Aegon Reinsurance Company of America, New York, NY	Aug. 17
SAFR Reinsurance Corporation of the U.S. New York, NY	Sept. 24
SAFR Reinsurance Corporation of the U.S. New York, NY	Sept. 29
Gan Anglo-American Insurance Company, New York, NY	Oct. 16
United Community Insurance Company, New York, NY	Oct. 27
Bausch & Lomb Insurance Company, Rochester, NY	Nov. 25

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (continued)

Guilderland Reinsurance Company, Delmar, NY	Dec. 8
Vesta American Reinsurance Corporation, New York, NY	Dec. 29

Restated Charters Filed

Colonial Indemnity Insurance Company, Kingston, NY	Oct. 8
Hospital Underwriters Mutual Insurance Company, Latham, NY	Oct. 22
U.S. Capital Insurance Company, White Plains, NY	Dec. 3

Changes of Name

"American Independent Reinsurance Company" to "Seven Hills Insurance Company," New York, NY	Jan. 8
"ERIC Reinsurance Company" to "Executive Re Indemnity Inc.," Wilmington, DE	May 1
"Metropolitan Reinsurance Company" to "Metropolitan Group Property and Casualty Insurance Company," Newark, DE	June 5
"First International Reinsurance Company" to "Cove Reinsurance Company," Dover, DE	July 15
"Aegon Reinsurance Company of America" to "CORPA Reinsurance Company," New York, NY	Aug. 17
Gan Anglo-American Insurance Company" to "Gan National Insurance Company," New York, NY	Oct. 16

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (continued)

Changes in Authorized Capital

Hermitage Insurance Company, White Plains, NY (from $1,095,000 to $1,500,150)	Jan. 28
Exchange Insurance Company, Buffalo, NY (from $3,309,610 to $3,209,713)	Feb. 7
American International Insurance Company, New York, NY (from $2,500,000 to $5,000,000)	Mar. 30
American National Fire Insurance Company, New York, NY (from $2,500,000 to $3,000,000)	May 6
SAFR Reinsurance Corporation of the U.S., New York, NY (from $4,800,000 to $32,327,136)	Sept. 24
SAFR Reinsurance Corporation of the U.S., New York, NY (from $32,327,136 to $4,800,000)	Sept. 29
United Community Insurance Company, New York, NY (from $2,500,000 to $3,000,000)	Oct. 27
Vesta American Reinsurance Corporation, New York, NY (from $3,000,000 to $8,188,000)	Dec. 29

Changes in Capital Structure

Hermitage Insurance Company, White Plains, NY (from $1,095,000 to $1,500,150)	Jan. 28
United Reinsurance Corporation of New York, New York, NY (from $2,500,000 to $2,500,000)	Mar. 11

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (continued)

American International Insurance Company,
New York, NY.
(from $2,500,000 to $5,000,000)............................ Mar. 30

American National Fire Insurance Company,
New York, NY
(from $2,500,000 to $3,000,000)............................ May 6

Unione Italiana Reinsurance Company of America,
New York, NY
(from $7,375,000 to $4,351,250)............................ May 11

SAFR Reinsurance Corporation of the U.S.,
New York, NY
(from $4,800,000 to $32,327,136).......................... Sept. 24

SAFR Reinsurance Corporation of the U.S.,
New York, NY
(from $32,327,136 to $4,800,000).......................... Sept. 29

United Community Insurance Company,
New York, NY
(from $2,500,000 to $3,000,000)............................ Oct. 27

Vesta American Reinsurance Corporation,
New York, NY
(from $3,000,000 to $8,188,000)............................ Dec. 29

Merger Agreement Approved

Mony Reinsurance Corporation, of Dover, DE
into Folksamerica National Reinsurance Company,
of New York, NY,... Mar. 31

Redomestications Filed

Puritan Insurance Company, of Stamford, CT
from Connecticut to Missouri,................................ Sept. 2

American Loyalty Insurance Company, Minnetonka, MN
from Minnesota to Pennsylvania............................... Nov. 30

3. Changes in Status of Authorized Insurers During 1992

e. Property and Casualty Insurance Companies (concluded)

In Liquidation

American Pacific Asian Insurance Company,
New York, New York
(Incorporated, never licensed)
Order dated May 7, 1992, entered in New York County
May 15, 1992 filed in this Department May 26, 1992.

License Revoked

MCA Insurance Company,
Tulsa, OK
Order of Appointment Appointing Superintendent
of Insurance of the State of New York as
Ancillary Receiver, entered in New York County
on November 17, 1992, filed in this Department............ Nov. 23

f. Co-operative Fire Insurance Companies

Merger Agreements Filed

Schoharie & Schenectady Mutual Insurance Association,
of Esperance, NY into Eastern Cooperative
Insurance Company, of South Westerlo...................... July 1

The Co-operative Fire Insurance Corporation of
Bergholz, New York, of Niagara Falls, NY
into Bethlehem and New Scotland Mutual Insurance
Company, of Sand Lake, NY................................ Dec. 1

Restated Charter Filed

Wayne Cooperative Insurance Company,
Clyde, NY.. Jan. 24

Amendments to Charter Filed

Farmers' Town Mutual Insurance Company of Clinton,
Clinton Corners, NY...................................... Jan. 23
The Cooperative Fire Insurance Corporation
of Bergholz, New York,
Niagara Falls, NY.. Jan. 24
Pioneer Insurance Company,
Greenville, NY... Aug. 4

3. Changes in Status of Authorized Insurers During 1992

f. Cooperative Fire Insurance Companies (concluded)

Security Mutual Insurance Company, Ithaca, NY	Oct. 9
Otsego County Patrons Co-operative Fire Relief Association, Schenevus, NY	Nov. 12

Change of Name

"Eastern Cooperative Insurance Company" to "Eastern Mutual Insurance Company," South Westerlo, NY	July 1

g. Title Insurance Companies

Domestic Company Incorporated

Washington Title Insurance Company, County of Nassau, NY	Oct. 14

Foreign Company Licensed

Fidelity National Title Insurance Company of Pennsylvania, Reading, PA	Oct. 21

Change of Name

"Title Insurance Company of Minnesota" to "Old Republic National Title Insurance Company," Minneapolis, MN	Dec. 31

Merger Agreement Filed

Chicago Title Insurance Company of Maryland into Chicago Title Insurance Company, Kansas City, MO	Sept. 20

3. Changes in Status of Authorized Insurers During 1992

h. Mortgage Guaranty Companies

Foreign Company Licensed

Private Residential Mortgage Insurance Corporation,
Raleigh, NC.. Dec. 11

Merger Agreement Filed

FGIC Mortgage Insurance Company, New York, NY
into Private Residential Mortgage Insurance
Corporation,
Raleigh, NC.. Dec. 11

i. Financial Guaranty Companies

Domestic Company Incorporated

Municipal Insurers Reserve Corporation,
New York, NY... Dec. 21

Amendment to Charter Filed

Capital Markets Assurance Corporation,
New York, NY... Mar. 3

Changes in Authorized Capital

Financial Security Assurance Inc.
New York, NY
(from $2,500,000 to $15,000,000)........................... Sept. 28

Municipal Bond Investors Assurance Corporation,
Armonk, NY
(from $2,500,000 to $15,000,000)........................... Dec. 15

Changes in Capital Structure

Capital Markets Assurance Corporation,
New York, NY
(from $2,500,000 to $3,400,000)............................ Mar. 3

Financial Security Assurance Inc.
New York, NY
(from $2,500,000 to $15,000,000)........................... Sept. 28

Municipal Bond Investors Assurance Corporation,
Armonk, NY
(from $2,500,000 to $15,000,000)........................... Dec. 15

3. Changes in Status of Authorized Insurers During 1992

i. Financial Guaranty Companies
(concluded)

Restated Charters Filed

Financial Security Assurance Inc., New York, N Y	Sept. 28
Municipal Bond Investors Assurance Corporation, Armonk, NY	Dec. 15

j. Charitable Annuity Societies

Charitable Annuity Society Permits Issued

American Lung Association, Portland, ME	Jan. 24
Natural Resources Defense Council, Inc., New York, NY	June 16
Rensselaer Polytechnic Institute, Troy, NY	Oct. 20
Southampton Hospital Association, Southampton, NY	Nov. 12
Brooklyn College Foundation, Inc., Brooklyn, NY	Dec. 10
St. Lawrence University, Canton, NY	Dec. 11

Changes of Names

"Foundation for Christian Living A Church Corporation" to "Peale Center for Christian Living a Church Corporation," Pawling, NY	Sept. 8
"Africa Inland Mission, Inc." to "Africa Inland Mission, International, Inc.," Pearl River, NY	Oct. 1

k. Accredited Reinsurers

Recognized

Indianapolis Life Insurance Company, Indianapolis, IN	Apr. 22
Interstate Fire & Casualty Company, Chicago, IL	Dec. 3

3. Changes in Status of Authorized Insurers During 1992

k. Accredited Reinsurers (continued)

Withdrawn

League Life Insurance Company, St. Louis, MO	Jan. 1
Monumental General Insurance Company Baltimore, MD	July 3
Continental National Indemnity Company, Cincinnati, OH	Sept. 9
The Imperial Life Assurance Company of Canada, Toronto, Canada	Sept. 28
Imperial Casualty and Indemnity Company, Omaha, NE	Oct. 28
First State Insurance Company, Wilmington, DE	Dec. 31

Restated Charter Filed

The Summit Fidelity and Surety Company, Maumee, OH	Mar. 3

Amendments to Charter Filed

Hudson Life Reassurance Corporation, Shelton, CT	Feb. 10
Massachusetts Indemnity and Life Insurance Company, Boston, MA	July 1

3. Changes in Status of Authorized Insurers During 1992

k. Accredited Reinsurers (concluded)

Changes of Name

"Hudson Life Reassurance Corporation" to "American Skandia Life Reinsurance Corporation," Shelton, CT	Feb. 10
Massachusetts Indemnity and Life Insurance Company" to "Primerica Life Insurance Company," Boston, MA	July 1
"New England General Life Insurance Company" to "Nippon Life Insurance Company of America," Boston, MA	Apr. 27

Redomestications Filed

Nippon Life Insurance Company of America, Boston, MA (Delaware Corporation) to the State of Iowa	Apr. 27
Trustmark Life Insurance Company, of St. Paul, MN from Minnesota to Illinois	July 29

l. Fraternal Benefit Society

Amendment to Charter Filed

United Russian Orthodox Brotherhood of America, Pittsburgh, PA	Nov. 17

Name Change

"United Russian Orthodox Brotherhood of America" to "Orthodox Society of America," Pittsburgh, PA	Nov. 17

4. Examination Reports Filed During 1992

Domestic Life Insurance Companies

Name of Company	Made as of	Date Filed
American Centurion Life Assurance Company	Dec. 31, 1990	Mar. 18
American International Life Assurance Company of New York	Dec. 31, 1989	June 16
American Medical and Life Insurance Company	Dec. 31, 1991	Dec. 15
Bankers Life and Casualty Company of New York	Dec. 31, 1990	May 11
Canada Life Insurance Company of New York	Dec. 31, 1990	June 11
Columbian Mutual Life Insurance Company	Dec. 31, 1989	May 28
Empire Fidelity Investments Life Insurance Company	On Organization	June 24
Farm Family Life Insurance Company	Dec. 31, 1990	July 8
Financial Security Life Insurance Company	Dec. 31, 1990	Feb. 18
First Investors Life Insurance Company	Dec. 31, 1989	Mar. 20
First North American Life Assurance Company	On Organization	July 21
First Transamerica Life Insurance Company	Dec. 31, 1989	Mar. 27
First United American Life Insurance Company	Dec. 31, 1990	June 17
The Franklin United Life Insurance Company	Dec. 31, 1990	Oct. 19
IDS Life Insurance Company of New York	Dec. 31, 1989	Feb. 12
INA Life Insurance Company of New York	Dec. 31, 1989	June 25
International Life Investors Insurance Company	Dec. 31, 1989	Jan. 3
Lincoln Security Life Insurance Company	Dec. 31, 1989	May 28
Monitor Life Insurance Company of New York	Dec. 31, 1990	Mar. 23

4. Examination Reports Filed During 1992

Life Insurance Companies

Name of Company	Made as of	Date Filed
Mutual Life Insurance Company of New York	Dec. 31, 1987	Mar. 17
National Benefit Life Insurance Company	Dec. 31, 1990	Sept. 18
National Integrity Life Insurance Company	Dec. 31, 1989	May 18
New York Life Insurance Company	Dec. 31, 1989	May 7
Old Republic Life Insurance Company of New York	Dec. 31, 1989	June 25
Royal Life Insurance Company of New York	Dec. 31, 1990	Nov. 5
Standard Security Life Insurance Company of New York	Dec. 31, 1988	May 14
Thomas Jefferson Life Insurance Company	Dec. 31, 1989	Mar. 16
United Pacific Reliance Life Insurance Company of New York	Dec. 31, 1989	Sept. 14
The United States Life Insurance Company in the City of New York	Dec. 31, 1990	Dec. 4
Utica National Life Insurance Company	Dec. 31, 1991	Nov. 9

Foreign Life Insurance Companies

Name of Company	Made as of	Date Filed
Monarch Life Insurance Company	Agency Operations	May 26
Mutual Benefit Life Insurance Company	Agency Operations	June 15

Domestic Accident and Health Insurance Company

Name of Company	Made as of	Date Filed
American Patriot Health Insurance Company	Dec. 31, 1990	Aug. 13

Fraternal Benefit Societies

Name of Company	Made as of	Date Filed
Baptist Life Association	Dec. 31, 1991	Aug. 26
Polish National Alliance of Brooklyn, United States of America	Dec. 31, 1990	Apr. 21
Workmen's Circle	Dec. 31, 1990	May 6

4. Examination Reports Filed During 1992

Alien Fraternal Benefit Society

Name of Company	Made as of	Date Filed
Independent Order of Foresters	Dec. 31, 1990	May 6

Savings Banks (Life Insurance Department)

The Bowery Savings Bank	Dec. 31, 1990	Apr. 3
The East New York Savings Bank	Dec. 23, 1989	Mar. 3
The Long Island Savings Bank	Dec. 31, 1990	Apr. 29

Domestic Property and Casualty Insurance Companies

Allcity Insurance Company	Dec. 31, 1991	Dec. 3
American Independent Reinsurance Company	Dec. 31, 1990	Dec. 15
American National Fire Insurance Company	Dec. 31, 1990	Dec. 28
American Nisshin Insurance Company	Dec. 31, 1990	Jan. 13
Arista Insurance Company	Dec. 31, 1989	Dec. 17
Bausch & Lomb Insurance Company	Dec. 20, 1990	Jan. 23
Centurion Insurance Company	Dec. 31, 1991	Dec. 2
CIM Insurance Corporation	Dec. 31, 1990	Dec. 8
Colonial Indemnity Insurance Company	Dec. 31, 1990	May 29
Contractors Casualty and Surety Company	On Organization	Mar. 16
Country-Wide Insurance Company	Dec. 31, 1989	Mar. 25
Empire Insurance Company	Dec. 31, 1991	Dec. 3
Eveready Insurance Company	Dec. 31, 1990	Aug. 25
Executive Insurance Company	Dec. 31, 1990	Mar. 9
Fire Districts of New York Mutual Insurance Company, Inc.	Dec. 31, 1991	June 2
Gerling America Insurance Company	Dec. 31, 1990	May 22
Gotham Insurance Company	Dec. 31, 1990	May 19
Harco National Insurance Company	Dec. 31, 1990	Jan. 23
Hereford Insurance Company	Dec. 31, 1990	Feb. 18
Hermitage Insurance Company	Dec. 31, 1990	Oct. 16
Lloyds New York Insurance Company	On Organization	June 9

4. Examination Reports Filed During 1992

Domestic Property and Casualty Insurance Companies
(concluded)

Name of Company	Made as of	Date Filed
Motors Insurance Corporation	Dec. 31, 1990	Dec. 8
Navigators Insurance Company	Dec. 31, 1990	Jan. 13
New York Marine and General Insurance Company	Dec. 31, 1990	May 19
North American Reinsurance Corporation	Dec. 31, 1989	Dec. 31
Paladin Reinsurance Corporation	Dec. 31, 1989	Sept. 17
Paramount Insurance Company	Dec. 31, 1990	May 12
Public Service Mutual Insurance Company	Dec. 31, 1990	May 29
Putnam Reinsurance Company	Dec. 31, 1989	June 22
Rochdale Insurance Company	Dec. 31, 1990	Sept. 23
Scor Reinsurance Company	Dec. 31, 1989	Jan. 29
Seaboard Surety Company	Dec. 31, 1990	Oct. 23
Sorema North America Reinsurance Company	Dec. 31, 1991	Nov. 2
Southwest International Reinsurance Company	Dec. 31, 1989	Jan. 23
Transcontinental Insurance Company	Dec. 31, 1988	July 10
Vesta American Reinsurance Corporation	Dec. 31, 1991	Oct. 26

Alien Property and Casualty Insurance Companies
(U.S. Branch)

Name of Company	Made as of	Date Filed
China America Insurance Company, Ltd.	Dec. 31, 1989	May 6
Hansa Marine Insurance Company, Ltd.	Dec. 31, 1989	Jan. 3
Nichido Fire & Marine Insurance Company	Dec. 31, 1989	July 16
The Nissan Fire & Marine Insurance Company, Ltd.	Dec. 31, 1990	Oct. 23
Sumitomo Marine and Fire Insurance Company Limited	Dec. 31, 1988	Apr. 22
Swiss Reinsurance Company	Dec. 31, 1989	Dec. 4
Union & Phenix Espanol Insurance Company	Dec. 31, 1989	July 16

4. Examination Reports Filed During 1992

Domestic Financial Guaranty Insurance Companies

Name of Company	Made as of	Date Filed
Financial Guaranty Insurance Company	Dec. 31, 1990	Sept. 2
Municipal Bond Investors Assurance Corporation	Dec. 31, 1990	Feb. 18

Reciprocal Insurer

Name of Company	Made as of	Date Filed
Physicians Reciprocal Insurers	Dec. 31, 1989	Nov. 18

Assessment Co-operative Fire Insurance Companies

Name of Company	Made as of	Date Filed
Eastern Cooperative Insurance Company	Dec. 31, 1990	Jan. 14
Erie and Niagara Insurance Association	Dec. 31, 1989	Apr. 30
Hartwick Town Insurance Company	Dec. 31, 1991	Oct. 13
Pittstown Cooperative Fire Insurance Company	Dec. 31, 1990	Feb. 11
Walton Co-operative Fire Insurance Company	Dec. 31, 1991	Oct. 13
Wayne Cooperative Insurance Company	Dec. 31, 1990	Nov. 3

Advance Premium Co-operative Fire Insurance Companies

Name of Company	Made as of	Date Filed
Central Co-operative Insurance Company	Dec. 31, 1990	May 15
Colonial Cooperative Insurance Company	Dec. 31, 1990	Aug. 7
Co-operative Insurance Company of Western New York	June 30, 1992	Nov. 6
Security Mutual Insurance Company	Dec. 31, 1990	Sept. 4
United Frontier Mutual Insurance Company	Dec. 31, 1990	July 22

Domestic Title Insurance Company

Name of Company	Made as of	Date Filed
Transamerica Title Insurance Company of New York	Dec. 31, 1990	Aug. 21

4. Examination Reports Filed During 1992

Charitable Annuity Societies

Name of Company	Made as of	Date Filed
American Baptist Foreign Mission Society	Dec. 31, 1990	Mar. 3
American Baptist Home Mission Society	Dec. 31, 1990	Mar. 3
The Board of National Missions of the Presbyterian Church (U.S.A.)	Dec. 31, 1990	Mar. 10
Christian and Missionary Alliance	Dec. 31, 1991	Nov. 5
National Division of the General Board of Global Ministries of the United Methodist Church	Dec. 31, 1991	Dec. 28
Planned Parenthood of New York City, Inc.	Dec. 31, 1990	Apr. 2
The Salvation Army	Dec. 31, 1991	Dec. 28
Health Maintenance Organizations		
Prudential Health Care Plan of New York, Inc.	Dec. 31, 1988	May 12
Rochester Area HMO, Inc.	Dec. 31, 1989	Mar. 19
Non-Profit Corporations		
Blue Cross and Blue Shield of Central New York, Inc.	Dec. 31, 1989	June 12
Preferred Assurance Company	On Organization	Nov. 23
Pension Funds and Retirement Systems		
New York City Employees' Retirement System and New York City Employees' Group Life Pension Plan	June 30, 1989	Mar. 26
New York City Housing Police Officers Variable Supplements Fund	June 30, 1989	Jan. 7
New York City Housing Police Superior Officers Variable Supplements Fund	June 30, 1989	Jan. 6
New York City Transit Police Superior Officers Variable Supplements Fund	June 30, 1989	Jan. 6
Transit Police Officers' Variable Supplements Fund	June 30, 1989	Jan. 6

4. Examination Reports Filed During 1992

Underwriting Organization

Name of Company	Made as of	Date Filed
American Hull Insurance Syndicate	Nov. 30, 1990	Mar. 25

Miscellaneous Funds

Name of Company	Made as of	Date Filed
Aggregate Trust Fund	Dec. 31, 1988	Mar. 2
American Offshore Insurance Syndicate	Nov. 30, 1990	May 18
Fund For Reopened Cases	Dec. 31, 1990	Feb. 13
Mutual Corporations Inter-Re-Insurance Fund	Dec. 31, 1990	Mar. 23
Savings Bank Life Insurance Fund	Dec. 31, 1990	Jan. 6
Suffolk County Patrolmen's Benevolent Association Benefit Fund	Dec. 31, 1991	Aug. 17
Suffolk County Patrolmen's Benevolent Association Legal Services Fund	Dec. 31, 1991	Aug. 17
Water Quality Insurance Syndicate	Nov. 30, 1990	May 18

Rate Service Organization

Name of Company	Made as of	Date Filed
Automobile Insurance Plans Service Office	Dec. 31, 1978	Dec. 23

5. Liquidation, Rehabilitation, Conservation, and Ancillary Receivership Proceedings[a]

The principal activities of the Liquidation Bureau during 1992[b] were as follows:

- -- Rehabilitation of Executive Life Insurance Company and Interamerica Reinsurance Company continued.
- -- Liquidation of American Consumer Insurance Company, American Fidelity Fire Insurance Company, Bakers Mutual Insurance Company of New York, Carriers Casualty Company, Citizens Casualty Company of New York, Consolidated Mutual Insurance Company, Cosmopolitan Mutual Insurance Company, Dominion Insurance Company of America, Heartland Group, Inc. (NY Insurance Exchange Syndicate), Horizon Insurance Company, Ideal Mutual Insurance Company, KCC New York Syndicate Corporation, Long Island Insurance Company, Midland Insurance Company, Midland Property and Casualty Insurance Company, Nassau Insurance Company, Nem Re-insurance Corporation, New York State Trial Lawyers Insurance Company, Northumberland General Insurance Company (United States Branch), Pine Top Syndicate Inc., Professional Insurance Company of New York, Resources Insurance Company, Shamrock Casualty Company, Summit Insurance Company of New York, The Realex Group N.V., U.S. Risk Inc., Union Indemnity Insurance Company of New York and Whiting National Insurance Company continued.
- -- Ancillary Receivership of MCA Insurance Company commenced.

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[a] See Table 61: Insurance Company Liquidation, Rehabilitation, Conservation, and Ancillary Receivership Proceedings as of December 31, 1992; Table 62: Fraternal Benefit Society Liquidation Proceedings as of December 31, 1992, and Table 63: Welfare and Pension Fund Liquidation Proceedings as of December 31, 1992.

[b] For earlier developments on liquidation and rehabilitation proceedings continued in 1992, see the Annual Report of the Superintendent to the New York Legislature for prior years.

-- Ancillary Receivership of American Druggists' Insurance Company, American Mutual Insurance Company of Boston, American Mutual Liability Insurance Company, Columbus Insurance Company, Edison Insurance Company, Great Atlantic Insurance Company, Great Global Assurance Company, Integrity Insurance Company, Oil and Gas Insurance Corporation, Proprietors Insurance Company, Security Casualty Company, The Mutual Fire, Marine and Inland Insurance Company, Transit Casualty Company, Western Employers Insurance Company and Yorktown Indemnity Company continued.

-- Conservation of Njord Insurance Company Ltd, United International Insurance Company and Walbrook Insurance Company commenced.

-- Conservation of Central Fire and General Insurance Company, Ltd., Colonial Assurance Company, Ltd., Dover Insurance Company, Ltd., El Paso Insurance Company, Ltd., Enterprise Insurance Company, Imperial Insurance Company, Kingscroft Insurance Company, Ltd., Lime Street Insurance Company, Ltd., Mentor Insurance Company, Ltd., Mentor Insurance Company (U.K.) Ltd., Mission Insurance Company, Mission National Insurance Company, Mission Reinsurance Company, Mutual Reinsurance Company, Ltd., Northeastern Fire Insurance Company of Pennsylvania, Northumberland Insurance Company, Ltd., Northumberland General Insurance Company, 41-Trust, Pacific and General Insurance Company and River Plate Reinsurance Company, Ltd., continued.

a. Insurance Companies in Liquidation, Rehabilitation, Conservation and Ancillary Receivership

On December 31, 1992, there were 28 liquidation proceedings, 2 rehabilitation proceedings, 22 conservation proceedings and 16 ancillary receivership proceedings that had not yet been closed by filing of Final Accountings with the Supreme Court. Their status (excluding rehabilitation proceedings) was as follows:

57 proceedings - evaluation of claims by Liquidation Bureau not completed.

7 proceedings - Liquidator's Report, Audit and Petition filed. Partial distribution made.

2 proceedings - Liquidation completed except for preparation and filing of Final Accounts and discharge of Liquidator.

As of December 31, 1992, the remaining assets involved in 65 of the 68 liquidation, rehabilitation, conservation, and ancillary receivership proceedings totaled $5,795,755,443.37, consisting of $1,961,806,353.87 in cash and $3,833,949,089.50 in other assets at book value.

During 1992, cash payments on allowed claims of creditors totaled $72,536,673.03 including payments made from security funds, but not including payments made by independent and ancillary receivers.

b. Fraternal Benefit Societies in Liquidation

As of December 31, 1992, there were 285 liquidation proceedings that had not yet been closed by filing of Final Accounts with the Supreme Court. Their status was as follows:

57 proceedings - evaluation of claims by Liquidation Bureau not completed.

2 proceedings - evaluation of claims by Liquidation Bureau completed. Liquidator's Report, Audit and Petition in preparation.

18 proceedings - Liquidator's Report, Audit and Petition filed and approved. Distribution pending.

190 proceedings - liquidation completed except for preparation and filing of Final Audit and Accounting.

18 proceedings - Final Audit and Accounting filed.

As of December 31, 1992, the remaining assets in the 285 liquidation proceedings aggregated $2,014,733.26 consisting of $1,827,175.07 in cash and $187,558.19 in other assets at book value.

During 1992, claims totaling $327,782.21 were allowed and paid, and surplus assets of $4,242,596.49 were paid to former members of the fraternal benefit societies.

c. Welfare and Pension Funds in Liquidation

As of December 31, 1992, there were five liquidation proceedings that had not yet been closed by filing of Final Accountings with the Supreme Court. Their status was as follows:

5 proceedings - evaluation of claims by Liquidation Bureau completed. Liquidator's Report, Audit and Petition in preparation.

As of December 31, 1992 the remaining assets of the five liquidation proceedings totaled $306,786.14 in cash and $3.00 in other assets. During 1992, no claim or surplus assets were paid to former members of the welfare funds.

Table 60
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
American Consumer Insurance Co.	03/26/86	(b) S-7603	$16,071,491.82		$1,663.041.18	$14,066,198.25
American Fidelity Fire Insurance Co.	03/26/86	(b) S-7603	29,544,693.40	$205,324.85	3,829,245.01	12,936,441.06
		S-7604	3,601,297.66			
		W.C.	652,022.92			
Bakers Mutual Insurance Co. of N.Y.	08/10/78	(c) S-7603	1,886,785.95	2,281,447.35	3,775,738.60	4,313,883.61
		W.C.	4,215,739.22			
		PLSF-85% DIV	1,602,301.90			
		WCSF-85% DIV	3,428,244.17			
		G.Cr-85% DIV	293,250.97			
		ANCI-85% DIV	2,030,323.39			
Carriers Casualty Company	10/21/86	(b) S-7603	4,860,678.19		1,637,435.47	4,286,797.36
		S-7604	(160,629.40)			
		W.C.	162,870.76			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Citizens Casualty Co. of N.Y.	06/17/71	(c) S-7603	$13,836,319.79	$2,328,754.47	$6,844,327.86	$10,339,950.88
		S-7604	264,262.41			
		W.C.	88,118.26			
		Pfd.	4.75			
		PLSF-50% DIV	6,456,500.06			
		MVSF-50% DIV	132,131.20			
		WCSF-50% DIV	44,059.13			
		G.Cr-50% DIV	1,811,606.65			
		ANCI-50% DIV	741,880.62			
Consolidated Mutual Insurance Co.	05/31/79	(c) S-7603	63,802,631.07	12,173,148.74	3,376,611.74	57,703,871.36
		S-7604	62,970.33			
		W.C.	14,410,668.31			
		PLSF-45% DIV	28,668,645.26			
		MVSF-45% DIV	28,336.65			
		WCSF-45% DIV	6,379,681.91			
		G.CR-45% DIV	1,498,094.88			
		ANCI-45% DIV	6,220,190.77			
Cosmopolitan Mutual Insurance Co.	10/24/80	(c) S-7603	39,529,398.49	24,592,810.68	8,314,478.04	54,509,221.60
		S-7604	370,775.63			
		W.C.	46,937,634.99			
		PLSF-40% DIV	15,795,933.98			
		MVSF-40% DIV	148,310.25			
		WCSF-40% DIV	18,518,971.12			
		G.Cr-40% DIV	439,036.77			
		ANCI-40% DIV	9,004,302.23			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid Class	Claims, Expenses and Dividends Paid Amount	Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992 Cash	Assets as of December 31, 1992 Other Assets
Dominion Insurance Co.	08/19/86 (b)				$4,064,857.60	$59,751,813.96
Heartland Group, Inc.	04/09/87 (b)				2,903,185.82	12,190,933.17
Horizon Insurance Co.	11/27/84 (b)	S-7603	$76,175,656.78	$11,416,304.10	3,344,322.28	51,912,658.03
Ideal Mutual Insurance Co.	02/07/85 (b)	S-7603	47,716,927.68	126,837,746.66	10,956,203.61	173,195,922.40
		S-7604	2,012.913.76			
		W.C.	17,327,988.20			
KCC New York Syndicate Corp.	06/26/91 (b)				1,113,518.88	56.35
Long Island Ins. Co.	05/31/79 (c)	S-7603	9,812,131.21	4,049,728.80	1,766,093.63	15,244,821.41
		S-7604	4,607.82			
		W.C.	2,750,028.13			
		PLSF-35% DIV	3,432,011.28			
		MVSF-35% DIV	1,612.74			
		WCSF-35% DIV	950,971.20			
		G.Cr-35% DIV	64,497.31			
		ANCI-35% DIV	300,201.91			
Midland Insurance Co.	04/03/86 (b)	S-7603	35,581,080.57	13,412,445.49	5,060,138.67	180,059,496.07
		S-7604	6,483,530.32			
		W.C.	4,974,426.59			
		ANCI-ADV.	2,377,526.39			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid Class	Amount	Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992 Cash	Other Assets
Midland Property and Insurance Co.	06/01/90 (b)				$1,900,529.25	$8,891,547.97
Nassau Insurance Co.	06/22/84 (b)	S-7603 S-7604	$25,852,498.60 11,840,004.71		301,485.21	15,744,643.36
Nem Re Insurance Corp.	09/06/90 (b)				5,276,176.38	1,915,302.82
New York State Trial Lawyers Ins. Co.	04/17/90 (b)				5,763.54	0.00
Northumberland General Ins. Co. (U.S. Branch)	07/31/85 (b)	S-7603	1,911,221.18		2,174,612.01	12,012,635.14
Pine Top Syndicate	02/26/88 (b)				1,469,389.35	2,507,425.31
Professional Ins. Co.	04/12/74 (c)	S-7603 PLSF-80% DIV G.Cr-80% DIV ANCI-80% DIV	43,618,549.42 34,259,997.54 702,440.73 1,323,420.95	3,039,404.13	7,950,422.38	11,964,913.51

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Resources Insurance Co.	07/23/77	(c) S-7603	$7,109,793.03	$5,785,105.34	$6,970,283.08	$5,601,214.55
		S-7604	4,370,085.46			
		W.C.	178,274.29			
		PLSF-35% DIV	3,909,420.14			
		MVSF-35% DIV	2,403,547.00			
		WCSF-35% DIV	98,050.86			
		G.Cr-55% DIV	680,100.50			
		ANCI-ADV DIV	3,154,360.77			
Shamrock Casualty Co.	07/25/74	(d) S-7603	5,786,304.25		68,236.79	4,890,710.95
		S-7604	6,201,992.39			
		Pfd.	1,242.37			
		PLSF-100% DIV	5,786,304.25			
		MVSF-100% DIV	6,201,992.39			
		G.Cr-100% DIV	38,753.60			
		INT.G.Cr	4,894,525.93			
Summit Insurance Co. of N.Y.	05/29/75	(d) S-7603	5,001,863.96	8,763,533.88	5,868,721.60	16,694,499.21
		S-7604	1,414,202.14			
		W.C.	11,073.86			
		Pfd.	76,525.71			
		PLSF-100% DIV	5,001,863.96			
		MVSF-100% DIV	1,414,202.14			
		WCSF-100% DIV	10,997.19			
		G.Cr-100% DIV	7,442,024.37			
		ANCI-100% DIV	7,625,242.85			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid Class	 Amount	Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992 Cash	 Other Assets
The Realex Group	12/30/87 (b)				$4,697,675.99	$23,219,069.91
U.S. Risk, Inc.	01/05/88 (b)				801,740.09	6,874,286.37
Union Indemnity Insurance Co.	07/16/85 (b)	S-7603	$95,140,606.93	$1,186,745.37	7,194,636.64	14,046,100.93
		S-7604	101,000.00			
		W.C.	991,906.57			
Whiting National Insurance Co.	11/21/88 (b)	S-7603	16,979,885.03		922,451.57	3,350,581.96
Rehabilitation Proceedings Not Completed						
Executive Life Ins. Co.	04/23/91				1,839,842,358.00	3,008,005,175.00
Interamerica Reinsurance	07/18/88				1,919,796.63	17,276,771.67

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Ancillary Proceedings Not Completed						
American Druggists' Insurance Co.	05/16/86	(b) S-7603 W.C.	$9,711,226.00 1,036,335.68		$598,887.94	$110,678.66
American Mutual Insurance Co. of Boston	04/10/89	(b) S-7603 S-7604 W.C.	7,448,030.71 102,540.98 17,679,464.97		912,164.03	1,300,391.61
American Mutual Liability Insurance Co.	04/10/89	(b) S-7603 S-7604 W.C.	10,207,410.08 192,699.74 18,447,289.29		1,139,146.40	1,370,291.22
Columbus Insurance Co.	02/15/85	(b) S-7603	4,002,906.74		320,324.90	14,844.17
Edison Insurance Co.	07/03/91	(b) S-7603	277,698.02		25,591.79	51,055.36
Great Atlantic Insurance Co.	10/20/89	(b) S-7603	8,862,622.63		280,750.61	1,060,354.26
Great Global Assurance Co.	01/30/89	(b) S-7603	225,547.89		7,886.04	512.67

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Integrity Insurance Co.	03/24/87	(b) S-7603	$26,608,578.77		$526,933.99	$2,070,009.54
		S-7604	85,811.02			
		W.C.	25,000.00			
		PLSF-EAD	3,015,607.00			
MCA Insurance Company	11/17/92	(b)				
Oil and Gas Insurance Corporation	10/31/90	(b) S-7603	208,157.79		12,471.27	66,162.88
Proprietors Insurance Co.	08/14/81	(b) S-7603	13,173,960.69		412,854.07	1,299,360.40
		PLSF-EAD	3,655,463.07			
Security Casualty Co.	04/28/82	(b) S-7603	21,090.50		16,163.51	83,370.68
		W.C.	261,768.85			
		PLSF-EAD	21,090.50			
		WCSF-EAD	240,207.50			
The Mutual Fire, Marine & Inland Insurance Co.	02/27/89	(b) S-7603	25,445,565.36		34,501.93	77,287.89
		PLSF-EAD	5,847,306.75			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Transit Casualty Co.	12/26/85 (b)	S-7603	$70,309,363.58		$1,161,033.82	$1,479,765.53
		S-7604	3,561,471.22			
		W.C.	2,317,687.39			
Western Employers Ins. Co.	06/27/91 (b)	S-7603	1,131,424.96		115,010.74	533,378.10
		W.C.	2,444,915.01			
		W.C. EAD	1,002,009.00			
Yorktown Indemnity Co.	05/10/89 (b)	S-7603	483,538.66		258,689.76	94,105.77
		S-7604	15,880,586.82			
Conservation Proceedings Not Completed						
Central Fire and General Insurance Co., Ltd.	06/24/82 (b)				109,405.57	75.56
Colonial Assurance Co.	02/11/85 (b)				34,545.82	1,823,334.16
Dover Insurance Co.	02/08/83 (b)				47,645.85	1,589,612.88
El Paso Insurance Co., Ltd.	08/06/91 (b)				1,541,364.04	

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid		Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992	
		Class	Amount		Cash	Other Assets
Enterprise Insurance Co.	04/01/87	(b) S-7603	$298,136.80		$58,286.24	$1,450.34
		W.C.	7,624.41			
		PLSF-EAD	39,534.00			
		W.C.- EAD	8,385.00			
Imperial Insurance Co.	02/09/78	(b) S-7603	6,790,939.04		5,000.00	39,018.13
		PLSF-EAD	3,060,000.00			
Kingscroft Ins. Co., Ltd.	08/06/91	(b)			1,540,818.63	
Lime Street Ins. Co., Ltd.	08/06/91	(b)				
Mentor Insurance Co. Ltd.	11/01/85	(b)			59,868.08	1,483,532.84
Mentor Insurance Co. (U.K.) Ltd.	03/29/89	(b)			1,774,124.32	86.85
Mission Insurance Co.	04/01/87	(b) S-7603	17,143,245.47		87,659.15	198,088.73
		S-7604	68,246.22			
		W.C.	1,223,794.60			
		PLSF-EAD	12,345,317.00			
		WCSF-EAD	697,547.00			

Table 61
INSURANCE COMPANY LIQUIDATION, REHABILITATION, CONSERVATION AND ANCILLARY RECEIVERSHIP PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Company Liquidation Proceedings Not Completed	Date Placed in Liquidation, Rehabilitation, Conservation or Ancillary Receivership	Claims, Expenses and Dividends Paid Class	Claims, Expenses and Dividends Paid Amount	Claims Paid by Independent & Ancillary Receivers	Assets as of December 31, 1992 Cash	Assets as of December 31, 1992 Other Assets
Mission National Ins. Co.	04/01/87	(b) S-7603 W.C. PLSF-EAD WCSF-EAD	$5,517,527.47 102,467.50 2,044,654.81 67.00		$110,735.70	$12,413.70
Mission Reinsurance Co.	04/01/87	(b)				310.79
Mutual Reinsurance Co.	08/09/91	(b)			1,540,818.63	
Northeastern Fire Ins. Co.	05/01/85	(b)			217,788.13	1,906,473.84
Njord Insurance Co., Ltd.	07/07/92	(b)				
Northumberland General Ins. Co., 41 Trust	02/08/85	(b)			1,219,976.60	11,526,995.30
Northumberland Insurance Co., Ltd.	12/17/74	(b) G.Cr-44% DIV EAD	1,192,398.02	$12,725.15	41,989.84	4.83
Pacific & General Ins. Co.	10/31/88	(b)			1,514,961.56	43.34
River Plate Reinsurance Co., Ltd.	02/08/88	(b)			36,295.14	1,500,381.80
United Int'l Ins. Co.	09/15/92	(b)			29,182.87	748,752.50
Walbrook Insurance Co.	09/22/92	(b)				

Table 61 - Footnotes and Symbols

[a] Dividends declared that the Liquidator has been unable to pay because the claimants have moved to unknown addresses, or for other reasons, are included in this statement as Dividends Paid, and the cash reserved for their payments is excluded from the asset shown. With the exception of collateral held in trust for the depositors or owners thereof, this statement includes all other assets, some of which are reserved for the payment of unadjudicated claims or other liabilities.

[b] Evaluation of claims by Liquidation Bureau not completed.

[c] Liquidator's Report, Audit and Petition filed and approved. Partial distribution made.

[d] Liquidation completed except for preparation and filing of Final Accounting and discharge of Liquidator.

EXPLANATIONS OF SYMBOLS DESCRIBING CLASSES OF ALLOWED CLAIMS AND SURPLUS DISTRIBUTIONS

G.Cr	General Creditor Claims
Pfd.	Preferred, Secured and Offsets
S-7603 & S-7604	Governed by Section 7603-7604 of Insurance Law and paid from Property and Liability or Motor Vehicle Security Funds
W.C.	Paid from Workers' Compensation Security Fund*
MVSF	Claim of Motor Vehicle Security Fund for claims and expenses paid
PLSF	Claim of Property and Liability Security Fund for claims and expenses paid
WCSF	Claim of Workers' Compensation Security Fund* for claims and expenses paid
LIGC	Paid from Life Insurance Guaranty Corporation Fund
ANCI	Claims of Insurance Guaranty Associations of other states
EAD	Early Access Distribution
INT.G.Cr	Interest on General Creditor Claims
D.S.S.	Distribution of Surplus Assets to Stockholders

* The Workers' Compensation Law was amended to consolidate the Stock Workers' Compensation Security Fund and the Mutual Workers' Compensation Security Fund into a single fund to be known as the Workers' Compensation Security Fund, effective March 1, 1990.

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Adath Morim K.U.V., et al.	09/27/89	(e) D.S.M G.Cr	$13,590.00 68.00	$592.09	$132.50
Akiba Egea Goodfellowship Fraternity, Inc.	03/19/91	(b)	0.00	336.98	1.00
Amschenover Independent Benevolent Soc., Inc.	02/06/81	(f) D.S.M. G.Cr	49,995.00 230.00	4,041.16	0.00
Anshe Achim Elizavetgrad Benevolent Assn., et al.	05/10/88	(e) D.S.M. G.Cr	0.00 0.00	0.00	0.00
Appel Benevolent Soc., Inc., et al.	11/15/85	(f) D.S.M. G.Cr	4,991.54 800.00	2,352.15	250.20
Assn. of Ekaterinoslaw	10/18/85	(e) D.S.M. G.Cr	65,177.00 100.00	30,525.71	0.00
Balbireshker Brotherhood Benevolent Assoc., Inc.	03/21/80	(e) D.S.M. G.Cr	13,364.00 50.00	63.67	13.00
Balta Benevolent Congregation in the City of NY	10/19/90	(b)	0.00	24,770.22	0.00
Benevolent Assn. of The Elites, Inc.	01/05/87	(e) D.S.M. G.Cr	0.00 0.00	0.00	0.00
Bessarabier Podolier Benevolent Soc., Inc., et al.	05/01/87	(e) D.S.M. G.Cr	2,294.00 9,950.00	2,878.55	313.28

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Beth Hamedrosh Hagodel We Tomache Torah of the Bronx, Inc.	03/09/81	(d) D.S.M. G.Cr	$6,000.00 1,100.00	$4,620.45	$786.56
Bethlehem Benevolent Society, Inc.	08/24/88	(c) D.S.M. G.Cr	7,434.00 3,184.00	2.57	0.00
Bichover Society, Inc.	01/29/79	(f) D.S.M. G.Cr	7,786.00 1,154.00	2,375.38	1.00
Biliner & Lonker Men's Benevolent Assoc., Inc., et al.	01/18/89	(b)	0.00	0.00	0.00
Bizoner Chebra B'nail Shule	01/24/77	(e)	0.00	0.00	0.00
Bolshowcer Sick & Benev. Association, Inc.	01/17/87	(d) D.S.M. G.Cr	33,120.00 6,300.95	2,603.92	933.32
Boro Friendship League Inc., et al.	06/21/89	(d)	0.00	515.02	0.00
Britchever Progressive Society, Inc.	12/28/79	(e) D.S.M. G.Cr	45,880.00 906.50	2,233.94	3.00
Bronx Bakers Mutual Aid Assn., Inc.	04/15/82	(e) D.S.M. G.Cr	35,956.00 1,089.60	2,981.00	982.80
Bronx Old Age Fund Assn.	04/28/86	(f) D.S.M. G.Cr	5,299.00 0.00	1,315.32	444.60

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Brotherly Aid Assn. of Brooklyn	06/22/77	(e)	0.00	0.00	0.00
Brothers in Unity, Inc.	12/05/78	(f) D.S.M. G.Cr	$21,156.00 0.00	$4,075.84	$ 336.66
Brothers of True Friendship	04/18/90	(b)	0.00	31,024.75	2,808.64
Bucowiner Boys Benevolent Society, Inc., et al.	02/22/89	(e)	0.00	0.00	0.00
Bucowiner Workingmen's Aid Society	12/01/78	(e) D.S.M. G.Cr	16,100.00 0.00	428.24	0.00
Buhusher Stefanester Society	03/07/80	(e) D.S.M. G.Cr	22,783.00 0.00	4,597.53	0.00
Butka Benevolent Society	10/14/87	(d)	0.00	8,973.40	1,236.67
Charles Polimer Lodge No. 416, et al.	02/16/88	(d)	0.00	473.43	0.00
Checkanover Young Men's Benevolent Assn.	06/28/82	(f) D.S.M. G.Cr	42,614.00 225.00	1,204.94	0.00
Chevra Bnei Sacoa Anshai Sherishon	12/22/92	(b)	0.00	0.00	0.00
Chevra Bnei Serheir Unterstutzung Verein	04/27/83	(e) D.S.M. G.Cr	24,079.00 712.00	5,807.99	2.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Chevra Gomlei Chesed Anshei Borisoff Inc., et al.	02/17/76	(e)	0.00	$2,391.22	0.00
Chevrah Agudath Achim Anshei Borisoff Inc., et al.	07/31/87	(e) D.S.M. G.Cr	$16,264.00 14,700.00	623.39	$ 59.08
Chevra Mogen David Anshei Brok	09/11/79	(e) D.S.M. G.Cr	20,787.00 635.05	1,646.56	2,542.56
Chevra Tifferes Israel Anshei Krasilov Slard	10/31/83	(e) D.S.M. G.Cr	47,928.00 914.00	6,122.13	495.00
Chevra Tillum and Mishnius Society et al.	09/27/90	(b)	0.00	22,348.72	0.00
Chevra Linas Hazedek Anshei Yecineve, et al.	01/07/91	(b)	0.00	46,294.16	2,970.00
Chief Rabbi Lieb Knepper Assn., Inc.	10/30/80	(e) D.S.M. G.Cr	7,264.00 0.00	668.50	0.00
Clairmount Club, Inc.	06/23/82	(f) D.S.M. G.Cr	111,892.00 50.00	4,591.94	780.72
Comac Club	06/18/81	(e) D.S.M. G.Cr	5,980.00 364.00	1,388.57	223.10
Congregation Ahavat Achim Anokei Moiler on Dneipper	04/08/75	(e)	0.00	0.00	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Congregation Ahavat Achim Mesilath Israel Anshe Byelsk, Inc.	04/21/77	(e)	0.00	0.00	0.00
Congregation Ahawath Shlomo	04/11/79	(e) D.S.M. G.Cr	$9,920.00 525.80	$1,581.10	0.00
Congregation Anshei Sorom Anshei	12/22/92	(b)	0.00	0.00	0.00
Congregation Ahavath Zedek Anshei Timkowitz, et al.	03/18/91	(b)	0.00	36,967.45	0.00
Congregation Asifas Israel	11/03/83	(e) D.S.M. G.Cr	15,871.00 0.00	2,469.93	$ 9.00
Congregation Beth David Agudath Achim, Inc.	01/11/84	(f)	0.00	0.00	668.55
Congregation Beth Hamedrash Hagodel Keser Torah Chono Dav.	02/15/79	(f) D.S.M. G.Cr	73,355.00 0.00	10,841.35	0.00
Congregation Bet Sholom Tomchei Harav, et al.	03/28/90	(b)	0.00	9,241.98	0.00
Congregation Bikur Cholim Inc., et al.	04/06/87	(f) D.S.M. G.Cr	48,336.00 2,950.00	7,697.35	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Congregation Bnei Isaac Anshe Narasow	10/04/83	(e) D.S.M. G.Cr	$57,600.00 0.00	$11,185.12	$ 369.58
Congregation Capooler Uterstitzung	03/13/75	(e)	0.00	0.00	0.00
Congregation Chevra Molodetsno, Inc., et al.	08/21/91	(b)	0.00	1,927.47	0.00
Congregation Dorshe Tove Anshe Pinsk	07/21/80	(e) D.S.M. G.Cr	26,812.50 822.68	6,003.18	0.00
Congregation Leisor Gans, Independent Przemsyler, et al.	06/20/89	(e) D.S.M. G.Cr	11,480.00	21.71	822.02
Congregation Mogen David Anshe Choroszc	12/16/82	(e) D.S.M. G.Cr	62,231.00 0.00	2,916.81	0.00
Congregation Nachal Itzchok Dorshe Tov, et al.	10/29/86	(e) D.S.M. G.Cr	52,000.00 16,150.00	22,990.96	1.00
Congregation Sons of Jacob Ticktiener Young Men's	08/10/90	(b)	0.00	56,003.45	930.05
Congregation Volin People of Maziv, et al.	12/13/89	(d)	0.00	22,116.69	1,392.53
Crown of Israel Soc., Inc.	10/24/85	(d)	0.00	5,607.98	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Czernowitz Bukowinaer Lodge, Inc., et al.	12/24/91	(b)	0.00	$17,373.37	0.00
Czortkower Rabbi J.M., Schapiro Society, et al.	11/14/89	(b)	0.00	49,551.97	$ 208.40
Derechiner Benevolent Assn., Inc.	10/01/81	(f) D.S.M. G.Cr	$8,190.00 50.00	,053.59	397.12
Drisser Benevolent Association, et al.	05/27/88	(e) D.S.M. G.Cr	21,600.00 3,000.00	649.83	0.00
Dubner Young Friends Association, et al.	10/14/88	(e) D.S.M.	13,110.00	2,245.12	1,529.64
Dubner Wohliner Society, et al.	11/02/88	(e)	5,616.00	2,029.88	0.00
East New York Progressive Society	10/06/92	(b)	0.00	1,500.00	0.00
Elon Association, Inc.	07/08/82	(e) D.S.M. G.Cr	27,184.00 0.00	724.50	0.00
Emanuel Morrel Foundation Inc.	01/27/81	(e) D.S.M. G.Cr	1,376.00 0.00	763.73	0.00
Endeavor Circle of Brooklyn, Inc.	12/26/79	(e) D.S.M. G.Cr	11,150.00 45.00	2,000.56	0.00

Table 62

FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]

AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Erste Boryslamer & Dombyczer Young Men's Benev. Assn.	03/20/79	(e) D.S.M. G.Cr	$ 572.00 200.00	$10,823.16	$271.93
Erste Briczaner Uterstitzungs Verein	04/22/77	(e)	0.00	0.00	0.00
Erste Istryer Congregation	08/22/80	(e) D.S.M. G.Cr	12,930.00 100.00	846.73	0.00
Erster Atiker Bessarabier K.U.V.	08/18/86	(e) D.S.M. G.Cr	32,505.00 125.00	3,615.83	85.64
Erste Romaner K.U.V.	08/06/86	(d)	0.00	682.01	400.29
Erster Knithinin Stanislauer Kranken Uterstitzung Verein	06/30/77	(e)	0.00	0.00	0.00
Erster Chmelniker Unterstutzungs Verein, et al.	10/20/87	(b) D.S.M. G.Cr	15,820.00 1,890.00	1,380.71	0.00
Erster Chorostkower Kranken Uterstulzungs Verein	04/04/90	(b)	0.00	10,628.20	3.00
Erster Sombur Kranken Unterstulzungs Verein	07/14/75	(e)	0.00	0.00	0.00
Eternal Young Friends, Inc.	01/23/80	(e) D.S.M. G.Cr	29,744.00 2,280.00	4,163.72	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid Class	Amount	Assets as of December 31, 1992 Cash	Other Assets
Family Mutual Aid Society	10/15/79	(f) D.S.M. G.Cr	$ 2,805.00 536.90	$ 106.66	0.00
Fannie Abrams Independent Benevolent Society	08/24/84	(f) D.S.M. G.Cr	15,768.00 615.00	3,370.83	$45.00
Fannie Siegel Berlader Ladies Sick Benevolent Assn.	09/10/82	(c)	0.00	0.00	0.00
First Belzian Bessarabian Benevolent Assn.	02/19/80	(f)	0.00	0.00	0.00
First Berlader Roumanian Benevolent Assn.	01/14/82	(f) D.S.M. G.Cr	19,682.00 807.00	3,071.35	1,784.25
First Bialykaminer Aid Soc.	02/20/86	(f) D.S.M. G.Cr	18,198.00 0.00	3,142.39	304.73
First Bolechower Sick Benevolent Assn., et al.	07/03/91	(b)	0.00	17,000.81	0.00
First Bottoschan American Sick Benefit Assn. et al.	05/28/85	(e) D.S.M. G.Cr	10,656.00 0.00	4,430.95	330.90
First Buzeur Benevolent Assn.	02/18/86	(e) D.S.M. G.Cr	19,152.00 0.00	3,242.19	2,922.21
First Dimerer Progressive Society	05/15/89	(b)	0.00	6,696.96	509.60

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings	Date Placed in	Claims and Dividends Paid		Assets as of December 31, 1992	
Not Completed	Liquidation	Class	Amount	Cash	Other Assets
First Elisavetgrader Benevolent Assn.	03/06/81	(f) D.S.M. G.Cr	$10,430.00	$563.47	$107.29
First Frompoler Podoler Benevolent Society Inc.	01/29/80	(e) D.S.M. G.Cr	14,282.00 0.00	594.58	0.00
First Haliczer Benevolent Assn., Inc.	01/30/79	(e) D.S.M. G.Cr	10,414.00 282.80	2,871.86	2,669.20
First Independent Gostyniner Benevolent Society	01/29/79	(e) D.S.M. G.Cr	25,833.00 695.17	631.66	2.00
First Ind. Husiatyner Sick Benevolent Society, Inc.	12/24/91	(b)	0.00	171.66	2.00
First Independent Securaner Sick & Benevolent Assn.	07/26/78	(e)	0.00	625.17	28.12
First Independent Strelisker Lodge, Inc.	03/09/81	(e) D.S.M. G.Cr	67,585.00 0.00	1,100.36	0.00
First Krasnostawer Young Men's Benevolent Society, et al.	06/21/91	(b)	0.00	16,454.36	1,880.10
First Krementchuger Benevolent Assn.	07/25/78	(e) D.S.M. G.Cr	13,000.00 400.00	10,557.09	3.00
First Koropiecer Benev. Assn.	05/29/92	(b)	0.00	0.00	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid Class	Claims and Dividends Paid Amount	Assets as of December 31, 1992 Cash	Assets as of December 31, 1992 Other Assets
First Korolowker Ladies Relief Society, Inc.	09/22/77	(e)	0.00	0.00	0.00
First Krilowitzer Young Friends Prog. Benev. Circle, et al.	05/23/90	(b)	0.00	$43,452.68	$ 1.00
First Mihowa Berhometh Bucowiner Sick Benevolent Society, et al.	04/27/87	(b) D.S.M. G.Cr	$9,960.00 14,067.00	1,118.57	12,888.67
First Nadworna Sick & Benevolent Assn.	04/31/84	(e) D.S.M. G.Cr	85,466.00 215.00	0.00	1,127.98
First Neurer Benevolent Society, et al.	05/04/88	(e) D.S.M. G.Cr	1,189.00 0.00	751.25	130.65
First Nova-Ushitzer Benevolent Assn., Inc., et al.	11/06/87	(b) D.S.M. G.Cr	17,030.00 5,400.00	4,326.12	0.00
First Povolotcher Benevolent Society	03/21/78	(e)	0.00	0.00	0.00
First Proskurov Young Men's Progressive Assn.	06/11/79	(e) D.S.M. G.Cr	15,458.00 0.00	1,037.48	1,978.98
First Przemysler sick Benefit Society, et al.	01/29/90	(b)	0.00	128,921.39	3.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings	Date Placed in	Claims and Dividends Paid		Assets as of December 31, 1992	
Not Completed	Liquidation	Class	Amount	Cash	Other Assets
First Rabbi Meyer Przemyslaner Sick Benevolent Assn., Inc.	02/06/85	(e) D.S.M. G.Cr	$26,060.00 0.00	$ 70.65	$ 29.37
First Rozistcher Benevolent Assn. Inc.	04/21/77	(e) D.S.M. G.Cr	37,113.00 705.00	2,592.75	0.00
First Roznow Galician Sick & Benevolent Society	04/05/82	(e) D.S.M. G.Cr	4,845.00 1,640.00	2,571.21	0.00
First Sadagoraer Young Men's Benevolent Assn.	07/16/73	(e)	0.00	0.00	0.00
First Tluster Brothers Benevolent Assn.	03/29/80	(e) D.S.M. G.Cr	4,202.50 856.50	831.00	2,218.10
First Ushitzer Padolier Benevolent Assn., et al.	08/24/87	(b) D.S.M. G.Cr	3,483.00 405.00	880.23	2,843.18
First Warkowitcher Wolyner Benevolent Assn.	09/17/81	(e) D.S.M. G.Cr	33,448.00 215.00	1,050.35	516.60
First Wasilover Brotherly Aid Society	03/21/80	(e) D.S.M. G.Cr	0.00 0.00	0.00	0.00
First Wielke Oczer Sick & Benevolent Assn.	09/19/84	(e) D.S.M. G.Cr	44,195.00 350.00	1,064.99	142.25
First Wolochisker Benevolent Assn.	08/22/84	(e) D.S.M. G.Cr	38,942.00 3,927.50	2,794.69	61.80

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
First Yaltuskower Benevolent Society, Inc., et al.	06/02/88	(f)	0.00	0.00	0.00
First Zaslawer Benevolent Assn., et al.	03/12/87	(d)	0.00	$ 304.06	$172.00
Freedom Benevolent Society Inc., et al.	12/17/91	(b)	0.00	854.37	3.00
Frei Budzanower Kranken Untersteutzung Verein	06/29/83	(e) D.S.M. G.Cr	$19,360.00 900.00	891.95	5,168.00
Friendship Group of Israel	06/27/79	(e) D.S.M. G.Cr	1,352.00 0.00	887.00	0.00
Garsony Krakauer S.B.S. et al.	01/19/90	(b)	0.00	382.00	0.00
Gottzolowai Benevolent Association	02/16/83	(e) D.S.M. G.Cr	7,287.50 108.00	1,734.73	72.50
Greater City Benevolent Association, Inc.	01/10/83	(e) D.S.M. G.Cr	11,259.50 0.00	939.20	16.00
Harlem Kurlander Young Men's Aid Society	12/02/81	(e) D.S.M. G.Cr	29,692.85 1,914.37	956.81	53.40
Hatikva Beneficial Society, Inc.	06/09/76	(e)	0.00	0.00	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid Class	Amount	Assets as of December 31, 1992 Cash	Other Assets
Homler Young Men's Society, Inc.	11/21/91	(b)	0.00	$ 20,044.33	$ 1.00
Horodischer Brothers Benevolent Assn., Inc.	01/10/83	(e) D.S.M. G.Cr	$16,358.00 652.00	3,348.42	404.00
Horodishter – Korsoner Lodge, Inc.	07/29/74	(e)	0.00	0.00	0.00
Hunts Point Chevra Bikur Cholin	10/31/80	(e) D.S.M. G.Cr	10,220.00 150.00	883.64	0.00
Husiatyne Sick & Benefit Society	11/28/75	(e) D.S.M. G.Cr	27,969.00 1,124.00	3,328.55	58.00
Hyfin Society, Inc., A/A Hyfin Society	07/24/91	(b)	0.00	147,816.51	0.00
Independent Bialystoker Brotherly Love Assn. #1	07/11/75	(e)	0.00	0.00	0.00
Independent Brotherhood of Yonkers, Inc.	05/15/78	(e) D.S.M. G.Cr	67,600.00 575.00	15,172.02	5,128.00
Independent Buczacer K.U.V. Kranken Unterstutzung Verein	12/04/81	(e) D.S.M. G.Cr	26,847.50 206.50	7,730.56	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Independent Chevra Achim Me Markower	05/22/80	(e) D.S.M. G.Cr	$9,347.00 550.00	$ 1,457.44	$13.00
Independent Chodorower Young Men's Aid Society	06/06/86	(e) D.S.M. G.Cr	69,674.00 25.00	5,124.45	417.48
Independent First Odessar Society of Brownsville	05/13/80	(e) D.S.M. G.Cr	5,600.00 425.00	353.12	0.00
Independent Geisen Benevolent Society, Inc., et al.	11/19/91	(b)	0.00	27,302.77	2.00
Independent Hebrew Ladies & Men's Benevolent Assn., Inc.	10/28/83	(e) D.S.M. G.Cr	6,222.00 124.68	624.86	0.00
Independent Horodoker Benevolent Aid Assn.	08/15/83	(d) D.S.M. G.Cr	0.00 446.49	3,775.09	271.04
Independent Israelites of Yonkers, et al.	01/29/88	(e) D.S.M. G.Cr	47,385.00 141,763.40	6,779.50	24,230.22
Independent Jarczower Young Men's Benevolent Assn.	10/15/82	(e) D.S.M. G.Cr	19,250.00 50.00	2,013.03	14.00
Independent Korwer Progressive Young Men's Benevolent Aid Society	02/25/85	(e) D.S.M. G.Cr	12,366.14 200.00	1,314.54	98.90

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Independent Orler Benevolent Society	01/06/87	(e) D.S.M. G.Cr	$ 37,185.96 0.00	$ 4,128.93	$3,850.12
Independent Podolyer Society of Brownsville, Inc.	10/15/92	(b)	0.00	0.00	0.00
Independent Proskurover Society, Inc.	07/02/92	(b)	0.00	8,847.70	0.00
Independent Radautz Bukowinaer Benev. Assn.	04/06/87	(e) D.S.M. G.Cr	32,564.00 500.00	3,816.22	1,132.38
Independent Skernewicer Benevolent Assn., Inc., et al.	10/13/87	(e) D.S.M G.Cr	33,892.00 15,625.00	3,011.09	0.00
Independent Society Sons of Abraham, Inc.	09/13/82	(e) D.S.M. G.Cr	24,734.00 175.00	459.17	122.58
Independent Sokolower Young Men's Benevolent Soc.	01/26/79	(e) D.S.M. G.Cr	18,252.00 150.00	2,171.55	288.00
Independent Tarnower Kranken Unterstutzungs Verein	11/14/78	(e) D.S.M. G.Cr	123,586.00 2,037.50	13,193.36	0.00
Independent Webster Ladies Benevolent Society, et al.	04/30/91	(b)	0.00	11,576.33	0.00

Table 62

FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]

AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Irving B. Vigdor Foundation Inc., et al.	02/23/88	(e) D.S.M. G.Cr	$10,500.00 250.00	$ 285.24	$700.60
Isidore Goldenberg Benevolent Assn.	02/16/77	(e) D.S.M. G.Cr	,110.00 0.00	128.21	0.00
James A. Garfield Society	06/13/80	(e) D.S.M.	20,333.00	695.23	0.00
Jewish American Workingmen Benevolent Society	06/27/90	(b)	0.00	14,223.61	0.00
Jewish Mayden Verein Inc.	10/04/84	(e) D.S.M. G.Cr	4,335.00 0.00	739.81	220.00
Joseph Eckert Aid & Benevolent Soc.	01/04/83	(e) D.S.M. G.Cr	44,776.00 4,000.00	4,051.20	79.04
Jupiter Benevolent Society, Inc.	08/25/76	(e)	0.00	0.00	0.00
Kadee Assn., Inc., et al.	09/27/89	(b)	0.00	3,950.85	0.00
Kalinkowitzer Progressive Aid Society	02/28/84	(e) D.S.M. G.Cr	36,608.00 50.00	354.01	87.96
Kaniev Stepenetz Benevolent Society	06/30/77	(e)	0.00	0.00	0.00
Kartuz Berezer Benevolent Association, Inc., et al.	10/03/88	(d) D.S.M. G.Cr	28,851.00 0.00	687.22	273.17

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Kehilath Temple Mason	06/05/79	(e) D.S.M. G.Cr	$11,509.00 0.00	$ 9,203.07	0.00
Kittiver Sick & Benevolent Society	02/10/81	(e) D.S.M. G.Cr	9,999.00 1,136.00	647.80	0.00
Kniazer and Mystikifker Aid Society	09/18/90	(b)	0.00	15,363.97	0.00
Kolchine Sick Support Society (The)	06/04/79	(e) D.S.M. G.Cr	10,776.25 1,100.00	814.40	$ 3.00
Kobriner Unterstutzungs Verein	03/11/83	(e) D.S.M. G.Cr	52,953.00 2,039.78	4,113.94	24.00
Kodima Benevolent Society	10/12/73	(e)	0.00	0.00	0.00
Kolbushower Teitlebaum Lodge 98, I.O.B.A.	08/25/76	(e)	0.00	0.00	0.00
Koniner Young Men's Benevolent Assn.	02/04/81	(b)	0.00	0.00	0.00
Kopaigorod Podolier Aid Association, Inc.	01/05/83	(e) D.S.M. G.Cr	8,860.00 0.00	1,457.98	546.64
Korelitzer Society, Inc.	07/22/80	(e) D.S.M. G.Cr	46,224.00 345.00	2,508.09	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Kovler Voliner Young Men's Benevolent	11/02/81	(e) D.S.M. G.Cr	$ 6,396.00 1,752.00	$ 4,165.74	$1,046.32
Kovner Unterstitzung Verein, Inc.	10/10/85	(e) D.S.M. G.Cr	10,457.00 60.00	1,103.75	9,334.12
Kozientzer Aid Society, Inc.	04/22/92	(b)	0.00	50,882.49	0.00
Krementchuger Ladies Benevolent Assn.	03/30/77	(e)	0.00	0.00	0.00
Kremintzer Congregation Beth David Anshei Poland	02/19/85	(e) D.S.M. G.Cr	860.00 0.00	562.19	0.00
Kroker Benevolent Assn.	06/14/82	(e)	0.00	0.00	0.00
Krynicaer Young Men's Benevolent Society	12/24/91	(b)	0.00	2,855.48	3.00
Kupiner Podolier	07/12/90	(b)	0.00	356.73	178.40
Landes Mutual Society, et al.	09/10/87	(b) D.S.M. G.Cr	2,403.00 400.00	445.38	2,029.33
Letichever Family Assn., Inc.	12/22/92	(b)	0.00	0.00	0.00
Liberty Brotherhood of 1917, Inc.	04/17/80	(e) D.S.M. G.Cr	31,654.00 1,290.97	709.99	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Lieder Brothers Benevolent Association, Inc.	08/17/88	(e) D.S.M.	$ 5,620.00	$ 833.29	$981.24
Lipkaner Bessarabier	08/18/80	(e) D.S.M. G.Cr	19,468.00 475.70	5,204.73	54.00
Local 338, Bagel Bakers Health & Welfare Fund	08/04/69	(e) D.S.M. G.Cr	47,564.00 1,870.00	23,735.65	0.00
Lodzer True Brothers Benevolent Society, et al.	03/18/91	(b)	0.00	44,223.66	3.00
Lomzer Young Men's Benevolent Assn.	09/23/85	(e) D.S.M. G.Cr	105,795.00 627.00	3,716.38	516.51
Louis Lerner Young Men's Association, Inc.	05/13/87	(e) D.S.M.	5,293.00	1,842.08	0.00
Louis Solomon Benevolent Society, Inc.	01/17/84	(e) D.S.M. G.Cr	39,264.00 1,770.00	6,878.10	10.00
Loyal Benevolent Soc., Inc.	11/12/81	(e) D.S.M. G.Cr	17,820.00 0.00	747.37	0.00
Lubaner & Ungegent Benevolent Society	07/22/76	(e)	0.00	0.00	0.00
Lubener Benevolent Society	04/24/81	(e) D.S.M. G.C	24,282.00 100.00	1,088.93	9.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Makarover Benevolent Assn.	02/24/87	(d)	0.00	$ 9,339.85	$ 105.06
Makower Uterstutzungs Verein	02/22/76	(e)	0.00	0.00	0.00
Manhattan Fraternal Assn., Inc.	04/24/79	(e) D.S.M. G.Cr	$ 7,692.00 200.00	1,590.28	0.00
Marmaros Benevolent Association, Inc.	12/14/83	(e) D.S.M. G.Cr	26,835.00 311.21	2,964.69	247.23
Max S. Levine Benevolent Society	11/27/84	(e) D.S.M. G.Cr	5,714.80 400.00	575.53	1,774.40
Minnie M. Friedman Ladies Benevolent Society	04/03/81	(e) D.S.M. G.Cr	19,380.00 15.00	1,293.70	0.00
Mirer Young Men's Benevolent & Educational Soc., et al.	11/15/89	(d)	0.00	38,768.56	0.00
Mistiscaver Vicinity Benevolent Assn.	09/18/82	(b)	0.00	0.00	0.00
Moholiv on Dneiper Ladies Benevolent	11/18/80	(e)	0.00	0.00	0.00
Montefiore Brotherly Benefit Association, et al.	12/11/91	(b)	0.00	11,776.06	2.00
Narevker Uterstutzungs Verein	05/03/78	(e)	0.00	0.00	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Nathan Marcus Benevolent Society, Inc.	03/09/76	(e)	0.00	0.00	0.00
National Welfare Assn. Inc.	11/17/80	(e) D.S.M. G.Cr	$ 3,060.00	$ 399.65	0.00
New Bessarabian Aid Assn.	07/16/82	(e) D.S.M. G.Cr	6,631.00 400.00	550.26	0.00
New Era Club a/k/a New Era Club, Inc., et al.	07/01/91	(b)	0.00	22,607.14	$ 1.00
Newmark Young Men's Benevolent Assn.	01/28/83	(e) D.S.M. G.Cr	29,377.00 2,625.00	1,211.48	378.00
Noah Benevolent Society	01/28/81	(e) D.S.M. G.Cr	64,064.00 3,210.00	47,192.01	28,890.49
Odesser Young Ladies Benevolent Assn.	08/05/81	(e) D.S.M. G.Cr	900.00 0.00	385.10	0.00
Old Sinover Independent Benevolent, Inc.	05/17/78	(b)	0.00	0.00	0.00
Olshaner Progressive Assn.	06/05/86	(e) D.S.M G.Cr	364.00 0.00	67.23	73.50
Onward Society Inc.	07/12/84	(e)	0.00	0.00	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Parnes Family Association, Inc.	11/10/86	(e) D.S.M. G.Cr	$ 3,892.00 7.15	$ 96.36	$ 280.00
Piateroter Young Men's Benevolent Assn.	10/22/82	(e) D.S.M. G.Cr	12,225.00 100.00	395.69	349.45
Pioneer Progressive Society, Inc.	08/28/92	(b)	0.00	6,649.94	3.00
Ponevezer Progessive Young Men's Benevolent Assn., et al.	10/31/90	(d)	0.00	36,194.12	1,023.30
Progress Mutual Aid Society	07/28/64	(e)	0.00	0.00	0.00
Progress Welfare Society	09/20/79	(e) D.S.M. G.Cr	2,214.00 75.00	14,076.87	346.60
Progressive Literary Aid Society	07/17/82	(e) D.S.M. G.Cr	95,512.50 550.00	6,271.02	0.00
Radomysler Benevolent Society, et al.	10/21/85	(e) D.S.M. G.Cr	75,924.00 10.51	5,527.76	823.48
Rifke Katlerow Assn., Inc.	07/31/78	(e) D.S.M. G.Cr	5,940.00	805.76	2.00
Rostover Help & Unterstutzung Verein Society	09/16/77	(e) D.S.M. G.Cr	39,897.00 1,386.00	10,468.23	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Roumanian Gomel Chesed Verein Assn.	11/18/80	(e) D.S.M. G.Cr	$61,422.00 100.00	$1,139.11	$519.60
Sabbath Observers of the Bronx, Inc.	04/28/86	(e) D.S.M. G.Cr	9,200.00 0.00	1,416.86	21.60
Sanhedrin Society, Inc.	07/24/79	(e) D.S.M. G.Cr	80,018.00 75.00	6,870.33	83.00
Saxonian & Thueringian Sick Benev. Assn. of Brooklyn	04/04/80	(e) D.S.M. G.Cr	13,133.45 0.00	601.44	0.00
Schkuder Young Men's Aid Society	08/28/81	(e) D.S.M. G.Cr	1,078.00 0.00	326.97	30.00
Second Krementchuger Benev. Assn.	01/09/79	(e) D.S.M. G.Cr	27,639.50 0.00	3,311.01	25.00
Shatover Podolier Society, Inc., et al.	05/03/89	(e) D.S.M.	12,852.00	1,568.03	3,844.73
Sisterhood of Odessa, Inc.	06/05/79	(e) D.S.M. G.Cr	18,859.50 25.00	3,214.16	0.00
Skoller Sick and Benevolent Assn. Inc.	06/15/82	(e) D.S.M. G.Cr	6,156.00 725.00	1,567.61	0.00
Sobolivker Chevra, et al.	05/19/88	(d) D.S.M. G.Cr	9,216.00 1,014.00	2,799.03	388.50

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Society for Reading Bible Rabbi Yankev Kopel et al., Inc.	04/03/85	(e) D.S.M. G.Cr	$7,644.00 1,000.00	$ 2,096.95	$ 298.11
Societe Israelite Francaise De Secours Mutuels De New York	01/15/85	(b)	0.00	1,607.40	7,436.63
Society Sons of Adam	05/22/74	(e)	0.00	0.00	0.00
Society Sons of Joseph	04/26/79	(e) D.S.M. G.Cr	4,018.00 150.00	3,376.10	1.00
Society Sons of the Land of Israel	05/22/92	(b)	0.00	61,951.89	5.00
The Society of 1867, Inc.	12/05/78	(e) D.S.M. G.Cr	3,000.00 475.00	5,030.81	0.00
Soloker Benevolent Association	10/30/90	(d)	0.00	27,037.94	0.00
Stocker Brothers Aid Society	02/29/80	(b)	0.00	702.53	2.00
Strecher Brothers Aid Assn.	10/13/81	(e) D.S.M. G.Cr	15,825.00 100.00	691.07	3,856.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Sudilkow Sick Support Society	02/13/86	(e) D.S.M.	$46,358.00	$4,889.71	$678.00
		G.Cr	3,475.00		
Sunshine Benevolent Association, Inc.	10/05/82	(e) D.S.M.	2,190.00	1,007.11	716.80
		G.Cr	100.00		
Szeniczer Sick & Benevolent	05/09/77	(e) D.S.M.	5,104.00	1,693.04	4.00
		G.Cr	1,175.00		
Tarascher Brotherly Society Inc.	08/16/83	(e) D.S.M.	30,600.00	4,802.68	2,596.00
		G.Cr	500.00		
Tarascher Progressive Benevolent Assn.	01/11/84	(e) D.S.M.	17,654.00	2,857.27	69.00
		G.Cr	50.00		
The Modern Ladies' & Men's Society, Inc.	08/31/77	(e)	0.00	0.00	0.00
Tolchener Benevolent Society	02/28/83	(e) D.S.M.	23,776.00	832.84	4.00
		G.Cr	774.00		
Tolochiner Friends Assn.	07/29/81	(e) D.S.M.	10,183.00	1,740.94	149.65
		G.Cr	546.00		
Topopower Sick Benevolent Society	06/14/77	(e)	0.00	0.00	0.00
Trembowla Brotherhood Benevolent Society, Inc.	09/22/87	(e) D.S.M.	67,167.00	5,877.66	341.30
		G.Cr	7,850.00		
True Fellowship Society	09/05/80	(e) D.S.M.	2,568.00	1,457.53	13.00
		G.Cr	1,275.00		

Table 62

FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]

AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
20th Century Benevolent Association	07/31/86	(d)	0.00	0.00	$6,832.12
Uller Benevolent Assn.	02/03/79	(e)	0.00	0.00	0.00
United Brothers Sick & Benevolent Assn., Inc.	10/02/81	(e) D.S.M. G.Cr	$ 986.00 0.00	$ 646.00	336.15
United Brothers Town of Brooklyn Aid Society	10/16/81	(e) D.S.M. G.Cr	1,360.00 0.00	1,573.11	503.42
United Hungarian Schifre Stein K.U.V.	01/21/80	(e)	0.00	874.82	0.00
United Mazirer Friends, et al.	04/20/88	(e) D.S.M. G.Cr	39,368.00 48.00	4,147.83	0.00
Vitebesk Benevolent Assoc.	02/13/92	(b)	0.00	39,494.72	0.00
Warshauer Help Society of the Bronx	12/03/73	(e) D.S.M. G.Cr	5,907.00 1,370.00	10,747.67	0.00
Welfare Liberty Fraternal & Benev. Society, Inc., et al.	04/28/89	(b)	0.00	15,143.84	0.00
West Side Brotherly Love Congregation & Benevolent Society	12/10/85	(e) D.S.M. G.Cr	24,542.00 24.00	57.36	0.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
West Side Hebrew Benevolent Society	07/05/79	(e) D.S.M. G.Cr	$43,136.50 214.00	$ 2,597.91	$6,308.61
Wiazener Benevolent Assn.	02/10/84	(e) D.S.M. G.Cr	6,594.00 0.00	1,111.01	22.14
William Mckinley Benevolent Assn., Inc.	04/18/85	(e) D.S.M. G.Cr	27,594.00 333.00	1,727.41	3,998.24
Wisoko-Litowsk Bruderlicher Unterstutzungs Verein, et al.	02/11/91	(b)	0.00	3,486.42	3.00
Wlozlawker Chevra Ahavas Achim	01/12/79	(e)	0.00	0.00	0.00
Wolkovisker Young Men's Benevolent Association	01/21/92	(b)	0.00	38,286.69	3.00
Yeshivath Torah Chaim of Harlem, Inc.	08/03/79	(e) D.S.M. G.Cr	38,904.00 530.00	1,178.37	693.00
Young Friends Assn.	06/29/84	(e) D.S.M. G.Cr	83,936.00 6,619.50	9,063.40	265.62
Young Men's Aid Society of Harlem	09/26/78	(e) D.S.M. G.Cr	21,509.00 0.00	1,339.03	4.00

Table 62
FRATERNAL BENEFIT SOCIETY LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Young Seekers of Friendship Benev. Society, Inc.	04/28/88	(d)	0.00	$ 848.35	$113.00
Zabludower Kranken Unterstutzungs Verein	03/12/82	(e) D.S.M. G.Cr	$6,142.00 874.00	824.44	103.17
Zaleszcyker Kranken Unterstutzungs Verein	05/20/77	(e)	0.00	378.24	56.00
Zamchower Progressive Benevolent Assn.	01/28/86	(e) D.S.M. G.Cr	19,273.00 272.00	2,139.09	52.50
Zenith Society, Inc.	05/20/82	(e) D.S.M. G.Cr	50,806.00 25.00	8,780.30	120.74
Zosler Protective Assn.	10/24/85	(e) D.S.M. G.Cr	6,018.00 14.00	1,978.19	124.36
Zwanitz Podolier Sick & Benevolent Assn.	07/12/83	(e) D.S.M. G.Cr	16,190.00 2,000.00	2,654.29	87.32

SOURCE: New York State Insurance Department

Table 62 - Footnote and Symbols

[a] Claims and distribution allowed that the Liquidator has been unable to pay because of unknown addresses, or for other reason, are included in this statement as Claims and Dividends Paid, and the cash reserved for their payments is excluded from the assets shown.
[b] Evaluation of claims by Liquidation Bureau not completed.
[c] Evaluation of claims by Liquidation Bureau completed, Liquidator's Report, Audit and Petition in preparation.
[d] Liquidator's Report, Audit and Petition filed and approved. Distribution pending.
[e] Liquidation completed except for preparation and filing of Final Audit and Accounting.
[f] Final audit and Accounting filed.

EXPLANATIONS OF SYMBOLS DESCRIBING CLASSES OF ALLOWED CLAIMS AND SURPLUS DISTRIBUTIONS

G.Cr	General Creditor Claims
D.S.M.	Distribution of Surplus Assets to Members

NOTE: In order to reflect a more accurate count, Fraternal Benefit Societies that were excluded due to inactivity or inconsequential dollar amounts were included beginning with the 1989 report.

Table 63
WELFARE AND PENSION FUND LIQUIDATION PROCEEDINGS[a]
AS OF DECEMBER 31, 1992

Liquidation Proceedings Not Completed	Date Placed in Liquidation	Claims and Dividends Paid		Assets as of December 31, 1992	
		Class	Amount	Cash	Other Assets
Factory & Building Employee Union Welfare Fund	01/24/72 (c)		0.00	$2,933.09	0.00
Organized Workers' Union of Building Service Employee Local 90 Pension Fund	10/30/67 (c)		0.00	84,437.11	0.00
Organized Workers' Union of Building Service Employee Local 90 Welfare Fund	07/10/67 (c)		0.00	37,006.70	$2.00
Local 719, Health and Welfare Fund	06/11/73 (c)		0.00	47,611.09	1.00
Local 1804-1, I.C.A. Welfare Fund	08/26/69 (c)		0.00	134,798.15	0.00

[a] Evaluation of claims by Liquidation Bureau completed. Liquidator's Report, Audit and Petition in preparation.

SOURCE: New York State Insurance Department

6. Insurance Department Receipts and Disbursements

Table 64
DEPARTMENTAL RECEIPTS FOR THE FISCAL YEAR
ENDED MARCH 31, 1992

Taxes Collected Under the New York State Insurance Law:	
Taxes collected by reason of retaliation under Section 1112	$ 8,435,916.28
Excess Line - Section 2118	14,318,026.35
Organization Tax - Section 180, Tax Law	23,430.38
Total taxes collected	$22,777,373.01*
Fees Collected Under Section 1112 of the New York State Insurance Law:	
Filing Annual Statements and Certificates of Authority to Companies	$ 54,695.81
Agents' Certificates of Authority	261,005.94
Total	$ 315,701.75
Licensing and Accreditation Fees:	
Agents' Licenses - Section 2103	$ 3,329,748.92
Adjusters' Licenses - Section 2108	77,475.00
Brokers' Licenses - Section 2104 and 2105	1,247,444.00
Bail Bond Agents' Licenses - Section 6802	1,450.00
Insurance Consultants' Licenses - Section 2107	47,570.00
Reinsurance Intermediary Licenses - Section 2106	110,900.00
Special Risk Licenses - Section 6302	128,000.00
Accredited Reinsurers - Section 107(a)2	126,000.00
Limited Lines	1,260.00
Total	$ 5,069,847.92
Assessments and Reimbursement of Departmental Expenses:	
Section 313 - Company Examinations	$ 9,232,207.62
Section 332 - Assessment	48,018,385.30
Section 7603 - Prop./Cas. Ins. Security Fund	37,694.00
Section 7604 - Pub. Motor Vehicle Liab. Security Fund	2,843.00
Article 6A - Workers' Comp. Security Fund	5,686.00
Section 9104/9105 - Tax Distribution	109,259.18
Regulation 68 - Health Services Arbitration Expenses	77,625.00
Regulation 68 - Processing Fee	21,000.00
Total	$57,504,700.10
Other Fees and Receipts:	
Section 9107 - Certification & Filing Fees	$ 130,164.45
Section 9108 - Fire Insurance Fee	9,496,934.33
Section 205 - Publications	7,579.74
Section 1212 - Summons and Complaints	84,820.05
Fines and Penalties	3,651,326.75
Arbitration Fees	518,040.00
FOIL Requests	64,783.89
Miscellaneous	6,741.18
Regulation 134	2,400.00
Total	$13,962,790.39
Total Departmental Receipts	$99,630,413.17

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* This amount is in addition to the $540,700,000 collected by the Department 30 Taxation and Finance under Article 33 of the Tax Law.

Table 65
INSURANCE TAX RECEIPTS*

(in millions)

Fiscal Year	Net
1987-88	$382.6
1988-89	415.5
1989-90	402.0
1990-91	445.0
1991-92	540.7

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* Collected by the Department of Taxation and Finance under Article 33 of the Tax Law.

Source: State of New York, Annual Budget Message, 1993-1994

Table 66
DISBURSEMENTS FOR THE FISCAL YEAR ENDED MARCH 31, 1992
PAID IN THE FIRST INSTANCE FROM APPROPRIATIONS

Chapter 050 - 1990-91	$ 2,432,372.98
Chapter 050 - 1991-92	$52,721,351.91
Personal Service	
Employee salaries	$33,269,169.85
Maintenance and Operation	
General office supplies	$ 433,579.97
Traveling expense	1,403,455.92
Rental equipment	9,130.47
Repair of equipment	80,732.79
Real estate rental	4,952,210.73
Postage and shipping	397,120.39
Printing	159,289.87
Telephone and telegraph	569,442.40
Miscellaneous contractual services	1,694,031.95
OGS E.D.P. rental	42,111.23
Equipment	2,446,863.95
Employee fringe benefits	9,696,585.37
Total maintenance and operation	$21,884,555.04
Total disbursements from first instance appropriations for fiscal year ended 3/31/92	$ 55,153,724.89
Total Department receipts for fiscal year ended 3/31/92	$ 99,630,413.17
Excess of Department receipts over Department disbursements	$ 44,476,688.28

7. Security Funds Income and Disbursements

Table 67
PROPERTY/CASUALTY INSURANCE SECURITY FUND[a]
Income and Disbursements
April 1, 1992

	To and including 3/31/91	4/1/91 to 3/31/92	As of 4/1/92
Paid into the Fund	$411,072,816.54	$ 98,504,795.66	$ 509,577,612.20
Interest income - net	377,294,734.20	3,625,914.35	380,920,648.55
Recoveries from companies in liquidation	111,896,031.62	24,951,619.14	136,847,650.76
Total	$900,263,582.36	$127,082,329.15	$1,027,345,911.51
Less disbursements:			
Administrative expenses	$ 565,329.09	$ 47,396.60	$ 612,725.69
Awards and expenses of companies in liquidation	651,476,456.00	93,018,136.95	744,494,592.95
Refunds and credits to companies	44,404,133.60	36,605.94	44,440,739.54
Transfers to other funds[b]	134,562,280.96	-0-	134,562,280.96
Total	$831,008,199.65	$ 93,102,139.49	$ 924,110,339.14
Total of Fund	$ 69,255,382.71	$ 33,980,189.66	$ 103,235,572.37
Cash in bank and U.S. securities (at par)	$ 69,255,382.71		$ 103,235,572.37
Total of Fund	$ 69,255,382.71		$ 103,235,572.37

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[a] Monies collected under Sections 7602 and 7603 of the Insurance Law

[b] State Purpose Fund - $47,562,280.96 + $87,000,000.00 per Chapter 55 of the Laws of 1982

Table 68
PUBLIC MOTOR VEHICLE LIABILITY SECURITY FUND[a]
Income and Disbursements
April 1, 1992

	To and including 3/31/91	4/1/91 to 3/31/92	As of 4/1/92
Paid into the Fund	$38,918,788.44	$ 1,899,993.70	$40,818,782.14
Interest income - net	20,837,522.02	571,908.50	21,409,430.52
Recoveries from companies in liquidation	12,101,689.56	2,891.34	12,104,580.90
Transfers	-0-	-0-	-0-
Total	$71,858,000.02	$ 2,474,793.54	$74,332,793.56
Less disbursements:			
Administrative expenses	$ 308,595.11	$ 13,591.47	$ 322,186.58
Awards and expenses of companies in liquidation	52,034,319.80	7,832,883.04	59,867,202.84
Refunds to companies	8,140,435.88	33,617.82	8,174,053.70
Total	$60,483,350.79	$ 7,880,092.33	$68,363,443.12
Total of Fund	$11,374,649.23	$ (5,405,298.79)	$ 5,969,350.44
Cash in bank and U.S. securities (at par)	$11,374,649.23		$ 5,969,350.44
Total of Fund	$11,374,649.23		$ 5,969,350.44

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[a] Monies collected under Section 7601 of the Insurance Law from companies writing bonds and policies carrying coverages set forth in Section 370 of the Vehicle and Traffic Law

Table 69
WORKERS' COMPENSATION SECURITY FUND[a]
Income and Disbursements
April 1, 1992

	To and including 3/31/91	4/1/91 to 3/31/92	As of 4/1/92
Paid into the Fund	$111,132,377.28	$ 4,517,139.49	$115,649,516.77
Interest income - net	104,373,055.81	2,495,519.97	106,868,575.78
Recoveries from companies in liquidation	27,178,125.78	2,182,620.55	29,360,746.33
Total	$242,683,558.87	$ 9,195,280.01	$251,878,838.88
Less disbursements:			
Administrative expenses	$ 593,249.01	$ 24,097.39	$ 617,346.40
Awards and expenses of companies in liquidation	106,513,665.93	17,905,946.48	124,419,612.41
Refunds to companies	27,380,760.32	73.00	27,380,833.32
Transfers	67,250,000.00	-0-	67,250,000.00
Total	$201,737,675.26	$17,930,116.87	$219,667,792.13
Total of Fund	$ 40,945,883.61	$(8,734,836.86)	$ 32,211,046.75
Cash in bank and U.S. securities (at par)	$ 40,945,883.61		$ 32,211,046.75
Total of Fund	$ 40,945,883.61		$ 32,211,046.75

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[a] On March 1, 1990, the Stock Workers' Compensation and Mutual Workers' Compensation Security Funds were consolidated into a single fund to be known as the Workers' Compensation Security Fund.